Child Fatality Report

Report Identification Number: NY-17-139

Prepared by: New York City Regional Office

Issue Date: May 22, 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: 17 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 12/07/2017
Initial Date OCFS Notified: 12/12/2017

Presenting Information

The 12/12/17 SCR report alleged that on 12/7/17, the 17-year-old SC was shot and killed in a gang related shooting. The SM was aware that the SC was an active gang member. The SC would come and go out of the home and did not attend school. The SM was unable to control the SC's behavior. The SC had experienced behavioral issues (ignoring curfew and truancy) since he was a preteen. The SM was given supports including preventive services and suggestions were made to increase the SC's supervision, follow up with the SC's school, file a Person in Need of Supervision (PINS) Petition and utilize LE and mobile crisis services. The SM failed to intervene. The SM did not follow through with any of the recommendations; as a result, the issues were ongoing. The role of the 16-year-old SS was unknown. The BF did not reside in the family home. He had no caretaking responsibility although he provided financial support.

Executive Summary

This 17-year-old SC was shot and killed on 12/7/17. The ME listed the preliminary cause of death as a gunshot wound and injuries, and the manner as homicide.

The 12/12/17 SCR report included the allegations of DOA/Fatality, IG and LS of the SC by the SM.

ACS interviewed the SM regarding the circumstances surrounding the SC's death. The SM stated the SC left New York State in September 2017. The SM was unaware of the SC's exact whereabouts, who the SC was with and who provided support and supervision. The SM stated the SC called her daily from an unknown phone number; therefore, she believed he was not in danger. The SC returned home in late November 2017. The SM stated the SC left New York State again on 11/29/17 and returned home around 10:00 PM on 12/6/17. The SM stated the SC left the home at approximately 1:00 AM on 12/7/17. The SM was unaware of the SC's whereabouts and activities during his time away from the family home. On 12/7/17, LE notified the SM of the SC's death.

The family resided in a 2-bedroom apartment. The family had adequate sleeping arrangements and a sufficient supply of food and supplies. The utilities were in functioning condition and included a working smoke/carbon-monoxide detector. The home was deemed suitable and safe for the SS.

At the time of the SC's death, ACS was in the process of investigating the 11/2/17 SCR report concerning allegations of IG, CD/AU, IG and EdN of the SS and IG of the SC by the SM. ACS conducted the 11/2/17 and 12/12/17 investigations simultaneously. The family attended the Child Safety Conference (CSC) via telephone. ACS offered services to the family, the SM accepted funeral/burial assistance. The family received PPRS including case management services.

On 2/9/18, ACS unsubstantiated the allegations of DOA/Fatality, IG, and LS of the SC by the SM on the basis that the SM ensured the SC's basic needs were met. The SM was providing a safe nurturing home at the time the SC was shot and killed in the community. Prior to the SC's death, services were in place; however, the SC continued to display severe behavioral issues. The SC refused to follow the SM's household rules and maintained gang involvement.

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?** No
  - **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:
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:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-Hour Fatality report was approved on 12/15/17; not within the required timeframe.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
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 approved on 1/23/18; not within the required timeframe.
Legal Reference:	CPS Program Manual, VIII, B.2, p.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 24 Hour Assessment
Summary:	The 24-Hour Safety assessment was approved on 12/15/17; not 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: 12/07/2017 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 05:38 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? No
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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	17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)

LDSS Response

ACS contacted LE and learned that the SC was murdered and the result of the investigation was pending. The SM was notified of the SC's death at 7:00 AM on 12/7/17. The SC's phone contained numerous messages from the SM requesting the SC return home prior to the fatality. There was no criminality concerning the SM's activities. No arrest was made and the criminal investigation was ongoing.

On 12/12/17, the CP stated during the family's weekly scheduled in-home session, the SM informed CP of the SC's death. The CP recalled that the family had been referred for services as a result of the 1/4/17 investigation. The family began services on 5/2/17. The family was engaged in sessions until 9/9/17, when the SC left the state without SM's knowledge and relocated to an unknown location with unknown individuals. CP last observed the SC in the home on 11/28/17.

On 12/14/17, the ME stated the SC died at approximately 5:38 AM on 12/7/17. The preliminary autopsy result showed the cause of death was listed as a gunshot wound to the torso with spinal cord, lung and vascular injuries. The SC's death was considered a homicide.

On 12/16/17, ACS visited the home and assessed the SS and living environment for safety. The SS appeared healthy and was observed without visible marks and bruises. It was unclear where the SS was at the time the SM received notification of SC's death.

On 12/20/17, ACS held a child safety conference (CSC) at the LDSS office. The attendees discussed the reported concerns with the family. Safety factors were identified for the SS. It was agreed that ACS would not seek Family Court action. ACS referred the family for a higher level of PPRS service.

On 1/19/18, ACS conducted a joint home visit with new PPRS provider. The CP described services provided and the SM signed the service agreement.

Official Manner and Cause of Death

Official Manner: Homicide
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
043068 - Deceased Child, Male, 17 Yrs	043069 - Mother, Female, 43 Year(s)	DOA / Fatality	Unsubstantiated
043068 - Deceased Child, Male, 17 Yrs	043069 - Mother, Female, 43 Year(s)	Lack of Supervision	Unsubstantiated

043068 - Deceased Child, Male, 17 Yrs	043069 - Mother, Female, 43 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:

The SC was not taken to the hospital by EMS nor seen by ER personal as the SC died on 12/7/17 in the community. The SS refused to provide release document for medical provider. The 24-Hour and 30-Day Fatality Reports were note approved timely.

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: ACS received notification of the SC's death on 12/12/17. The SS was not assessed face-to-face until 12/16/17.				

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?	☐	☒	☐	☐

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:
The family received PPRS.

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? No

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)
11/02/2017	Deceased Child, Male, 17 Years	Mother, Female, 43 Years	Inadequate Guardianship	Unfounded	Yes

Sibling, Female, 16 Years	Mother, Female, 43 Years	Childs Drug / Alcohol Use	Indicated
Sibling, Female, 16 Years	Mother, Female, 43 Years	Educational Neglect	Indicated
Sibling, Female, 16 Years	Mother, Female, 43 Years	Inadequate Guardianship	Indicated

Report Summary:
On 10/18/17, the SC went missing from the home. The SM was aware the SC was missing and had failed to file a missing person's report to document and provide awareness for SC's disappearance. The SS had only attended three days of school for the current school year and had a history of poor attendance. As a result, the SS was failing. The SM was aware of the SS failing grades and poor attendance and failed to intervene. SS was abusing marijuana. The SM was aware of the SS drug use and failed to intervene. The marijuana use caused the SS to sleep and as a result, the SS was unable to attend school. The role of the BF was unknown.

Determination: Indicated | **Date of Determination:** 12/31/2017

Basis for Determination:
ACS substantiated the allegations of CD/A, EdN and IG for the SS by the SM. ACS found credible evidence as the SS displayed behavioral issues for an extensive period of time, admitted to occasional marijuana use and confirmed not attending school regularly. The SM was aware and failed the take appropriate action to set limits, take action, enroll SS into drug treatment and ensure she attended school.

ACS did not find credible evidence to substantiate the allegation of IG of the SC by the SM as the SC was in contact with SM via text message and social media. The SC had a history of leaving the home for long periods of time and not informing SM of his exact whereabouts.

OCFS Review Results:
The ACS Specialist gathered sufficient information to make determination for all allegations including those on the SCR report in the course of the investigation. The safety decision recorded on the safety assessment at the time of the Investigation Determination was appropriate; however, the Investigative Decision for some allegations was not appropriate and was not commensurate with case circumstances. The Specialist completed all investigative actions as recorded.

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

Issue:
Appropriateness of allegation determination
Summary:
ACS inappropriately determined that the SC's contacts via text and social media was sufficient evidence to determine the SC was not in fact a missing person. The evidence proved the SC was alive, the SM was unaware of SC's whereabouts and not concerned to locate the SC as she failed to file a missing person report as instructed by PPRS.
Legal Reference:
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:
Failure to provide notice of report
Summary:
The BF was identified, however, the case record did not document that the BF was interviewed nor was an NOE provided to him during the investigation.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
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:
Failure to enter an incident date for substantiated allegations
Summary:
It was not observed that ACS entered the incident date for a substantiated allegation for each child. The Date/Time of Incident data field is located in the "Allegation" section in case record.
Legal Reference:
17-OCFS-ADM-03
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:
Failure to Provide Notice of Indication
Summary:
A NOI was not generated and provided to the SM for the investigation.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
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:
Mandated reporters did not report potential abuse or maltreatment of a child
Summary:
On 9/12/17, the SM informed the CP of the Jewish Child Care Association (JCCA) agency of the SC's absence from the home and of his unknown whereabouts with unknown individuals for an unknown period of time. CP spoke with the SC on 9/14/17; however, the SC did not reveal his whereabouts to CP. The CP filed a missing person report regarding the SC on 10/10/17. The SCR was not notified until 11/2/17.
Legal Reference:
SSL 413 and 415
Action:
JCCA 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:
Review of CPS History
Summary:
The ACS review of the subjects child welfare history was not complete. ACS was required to review of all prior child welfare history.
Legal Reference:

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.

Issue:

Assessment as to need for Family Court Action

Summary:

The documentation did not reflect that ACS discussed nor obtained a legal consult to assess whether legal action would have been appropriate or necessary, due to the fact there were multiple indicated reports for the same allegations prior to the investigation.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

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)
06/28/2017	Deceased Child, Male, 17 Years	Mother, Female, 43 Years	Excessive Corporal Punishment	Unfounded	Yes
	Deceased Child, Male, 17 Years	Mother, Female, 43 Years	Inadequate Guardianship	Unfounded	

Report Summary:

On 6/23/17, there was a disagreement between the SM and the SC that escalated. The SM took a broom or a mop stick handle and beat the SC over his shoulders and back area with the stick. The SC tried to get away from the SM by going into the bedroom, when he closed the door on the SM's arm. The police intervened and issued a full stay away OP against the SC and he was not supposed to be in the home. The SC had no place to go and remained in the home. It was unknown where the SS was when the incident occurred.

Determination: Unfounded | **Date of Determination:** 08/25/2017

Basis for Determination:

The allegations of L/B/W and IG were unsubstantiated due to lack of credible evidence gathered during the investigation. ACS had not observed marks or bruises on the SC's body. The SC admitted he was aggressive towards the SM twice during the incident and the SM admitted she used a broom stick to defend herself as she felt threatened and was afraid of the SC's temper. As a result, the SC was arrested for his aggressive behavior and an OP was issued for the SM against the SC.

OCFS Review Results:

ACS reviewed the family's previous CPS history, obtained information from collateral contacts, assessed children's environment for safety and interviewed each child and the SM. ACS obtained relevant information from PPRS agency. During the telephone interview with the BF, ACS attempted to elicit his suggestions and recommendations regarding the SC and SS behaviors.

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

Issue:

Failure to provide notice of report

Summary:

The record did not reflect that ACS generated and provided a NOE to the SM or the BF.

Legal Reference:

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

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:

The safety assessment was approved timely on 7/5/17; however, the progress notes required to approve an adequate safety assessment were not documented until after the approval on 7/6/17. The 7-Day Assessment did not contain selected safety factors that adequately assessed the behaviors and circumstances identified in the progress notes.

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:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP elements did not include accurate responses regarding SM's expectations of the children and whether SM prioritized the needs of the children above her own. The family's financial resources and constructive supports were not addressed in detail. The SM, SC and SS acknowledged the BF provided financial support and visited the home; however, the BF was not listed as the Secondary Caretaker.

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:

Overall Completeness and Adequacy of Investigation

Summary:

ACS missed opportunities to obtain information as the agency did not identify family's supports, failed to clarify subjects' contradictory statements, did not complete a full financial assessment, attempt to involvement the BF in the FTM, and determine if the minor child (for whom the SM provided babysitting services) was present during episodes of family violence.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/04/2017	Deceased Child, Male, 16 Years	Mother, Female, 42 Years	Educational Neglect	Indicated	Yes
	Deceased Child, Male, 16 Years	Father, Male, 46 Years	Educational Neglect	Indicated	
	Sibling, Female, 15 Years	Father, Male, 46 Years	Educational Neglect	Indicated	
	Deceased Child, Male, 16 Years	Mother, Female, 42 Years	Childs Drug / Alcohol Use	Unfounded	
	Deceased Child, Male, 16 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 15 Years	Mother, Female, 42 Years	Educational Neglect	Indicated	

Report Summary:
The SM was unable to manage the SC's behaviors. As a result, the SC was out of control and did whatever he wanted. The SC damaged property, punched holes in the walls and verbally threatened the family when upset. The SC smoked marijuana almost daily for nearly a year. The SC was frequently absent from school. The SS and BF had unknown roles.

Determination: Indicated **Date of Determination:** 03/04/2017

Basis for Determination:
ACS substantiated the allegation of EdN of the SC and SS by the SM on the basis that both children admitted they had not attended school regularly. The SM was aware the SC and SS did not attend school and the SM failed to take suggested and necessary action to mediate the situation. The SC and SS continued their truant behaviors during school hours.

ACS unsubstantiated the allegation of IG and CD/A of the SC by the SM as the SM provided the SC with his basic needs on a daily basis and encouraged him to attend school although SC refused to attend. The SC admitted to using marijuana that he obtained from friends. The SM refused to provide SC with money when she became aware of his drug use

OCFS Review Results:
ACS entered timely progress notes and reviewed prior CPS history. ACS made significant collateral contacts and assessed the living environment for safety. There was sufficient and relevant face-to-face contact with the SC, SS and SM. ACS made service referral for the family.

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

Issue:
Failure to Provide Notice of Indication
Summary:
The review of the investigation revealed the SM and BF were not provided a NOI.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
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:
Failure to provide notice of report
Summary:

Although the BF was interviewed via phone, the documentation did not reflect that a NOE was provided to the BF.

Legal Reference:

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

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:

Although the BF did not reside in the home he should have been listed as a Secondary Caretaker in the RAP. The BF and the family acknowledged his financial responsibilities to care for the children and ACS added the BF as a subject to the report.

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:

Appropriateness of allegation determination

Summary:

ACS substantiated the allegation of EdN of the SC and SS by the SF. The determination of the EdN allegation of the SC and SS by the BF was not appropriately determined because information gathered did not support the determination. Statements made by the BF, SM, SC and SS confirmed the BF was not informed nor aware that the SC and SS were not attending school regularly.

Legal Reference:

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:

Overall Completeness and Adequacy of Investigation

Summary:

During the investigation, the SM was the caretaker of a minor child on daily basis in the home. ACS had not identified and assessed the child nor was the SM's home environment adequately assessed for the caretaking of a minor child.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/24/2016	Deceased Child, Male, 16 Years	Mother, Female, 41 Years	Educational Neglect	Indicated	Yes
	Sibling, Female, 14 Years	Mother, Female, 41 Years	Educational Neglect	Indicated	
	Deceased Child, Male, 16 Years	Mother, Female, 41 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 14 Years	Mother, Female, 41 Years	Inadequate Guardianship	Indicated	

Report Summary:
The SC had 53 school absences. As a result, the SC was failing all his classes. Phone calls were made and letters were sent to the SM; however, the SC continued to miss school. The SC had 59 absences the prior school year.

The subsequent 4/15/16 report stated that the SS had 73 days absent since the school year began and as a result, she was failing all her classes. The SM failed to address the problem and had no control over the SS and the SC had the same attendance issues.

Determination: Indicated **Date of Determination:** 05/23/2016

Basis for Determination:
ACS gathered credible evidence to substantiate the allegations of EdN and IG of the SC and SS by the SM on the basis that the SM was aware of the of the children's history of and ongoing excessive unexcused school absences. ACS found that the SM refused to address the reported concerns and had not met the minimum standard of care for the children.

OCFS Review Results:
During the review, ACS investigated the allegations of the 3/24/16 and 4/15/16 reports simultaneously. ACS reviewed the family's child welfare history, obtained relevant information from collateral contacts, assessed children's environment for safety and interviewed each child and the SM. ACS provided required notification to the SM and obtained release for information. ACS referred the family for services.

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

Issue:
Failure to provide notice of report
Summary:
The BF was not contacted nor provided a NOE. The identity and contact information for the BF was noted in prior reports.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
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:
Failure to Provide Notice of Indication
Summary:
The documentation did not reflect that the NOI was generated nor provided to the SM.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

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 face-to-face contacts with the child and/or child's parents or guardians
Summary:
The face-to-face interviews with the SM and children were not thorough. The discussions surrounding the current allegations, past CPS history and services were not sufficient to address the issues and necessary intervention.
Legal Reference:
18 NYCRR 432.1 (b)(3)(ii)(a)
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:
There were progress notes dated 3/31/16 and 4/5/16 that were entered on 5/23/16. Progress notes should be recorded contemporaneously to preserve the accuracy and integrity of the information being recorded.
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:
Timely/Adequate Seven Day Assessment
Summary:
ACS was aware of the family's prior CPS history and the current allegations; however, the SM and children were not interviewed in the home or in the school within 7 days of notification of the report. ACS was unclear about the whereabouts of the children. The safety decision and the safety factors listed in the 7-Day safety assessment document were recorded incorrectly.
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:
Adequacy of Risk Assessment Profile (RAP)
Summary:
Although the BF did not reside in the home he should have been listed as a Secondary Caretaker. The BF and the family acknowledged there were visits with the BF who provided financial support to the SM and children.
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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/13/2015	Sibling, Female, 14 Years	Mother, Female, 41 Years	Educational Neglect	Indicated	Yes
	Deceased Child, Male, 15 Years	Mother, Female, 41 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 15 Years	Mother, Female, 41 Years	Lack of Supervision	Unfounded	
	Deceased Child, Male, 15 Years	Mother, Female, 41 Years	Educational Neglect	Indicated	

Report Summary:
The SS missed 15 days of school and had cut school 43 times. As a result, she was failing all seven of her classes. Numerous phone calls and letters were sent to the SM and conferences were set up, yet the SM refused to take action to ensure the SS attended school regularly.

The 12/2/15 Subsequent report stated the SC had a history of skipping school and acting out behaviorally and required a higher level of supervision. The SM was unable or unwilling to provide adequate supervision of the SC. As a result the SC skipped 6 of 21 days of school. The SM was unaware of the SC's whereabouts during the day and failed to intervene.

Determination: Indicated **Date of Determination:** 12/30/2015

Basis for Determination:
ACS substantiated the allegation of EdN of the SC and SS by the SM on the basis the SS had poor attendance history, the SM was aware and allowed the SS to stay home instead of attending school.

ACS unsubstantiated the allegation of IG and LS of the SC and IG of the SS by the SM on the basis that the SM was unable to control the SC's behavior. The SM did not have support in NYC; therefore, she sent the SC out of the country to be cared for by relatives.

OCFS Review Results:
During the review, ACS investigated the allegations of the 11/13/15 and 12/2/15 reports simultaneously. ACS reviewed family's previous child welfare history, obtained relevant information from relevant collateral contacts, assessed children's environment for safety, and interviewed each child and the SM. ACS provided required notification to the SM, obtained release for information, made a home and school visit.

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

Issue:
Failure to provide notice of report
Summary:
The identified BF was not provided a NOE.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
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:
Failure to Provide Notice of Indication
Summary:
ACS had not documented that an NOI was provided to the SM nor was an NOI generated.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
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 identified BF of the children did not reside in the family home. The family acknowledged the BF provided financial support to the children and was present when needed. ACS did not include the BF as a Secondary Caretaker in the RAP.
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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/21/2015	Deceased Child, Male, 15 Years	Mother, Female, 41 Years	Educational Neglect	Unfounded	Yes

Report Summary:
The SC was absent from school 85 days during the school year and failed every class, as a result. The SM was aware but failed to address the issue. As a result, the SC continued to be absent.

Determination: Unfounded | **Date of Determination:** 05/07/2015

Basis for Determination:
ACS unsubstantiated the allegation of EdN of the SC by the SM on the basis the SM sent the SC out of the country to reside with relatives.

OCFS Review Results:
The Specialist gathered sufficient information to make determination for all allegations including those on the SCR report in the course of the investigation. The safety decision recorded on the safety assessment at the time of the Investigation Determination was appropriate; however, the ACS Investigative Determination narrative was not appropriate and did not reflect the case circumstances. The Specialist completed all investigative actions.

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

Issue:
Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:

There was some credible information gathered to substantiate the allegation as the SM was aware of the SC's truancy history and drug use. The SM's did not attempt to follow up with recommendations to manage the SC's behavior. The SM sent the SC to reside with relatives and receive treatment.

Legal Reference:

SSL 412(1) and 412(2)

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:

Failure to Offer Services

Summary:

ACS had knowledge of findings of the 12/14/14 investigation where the agency verified the children's truancy, the SM's inability to manage the children's behavior and her refusal of PPRS. It was necessary for ACS to reiterate to the SM the importance for the family to engage in counseling and continue attempts to offer services.

Legal Reference:

SSL 424(10); NYCRR 428.6

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:

ACS did not obtain key information to address the allegation of EdN. Despite conducting visits to the SC's school to interview staff, ACS failed to obtain relevant information and documentation. It was necessary to obtain records regarding the SM's unwillingness/inability to respond to school notification, and review the child's attendance record.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/18/2014	Sibling, Female, 13 Years	Mother, Female, 40 Years	Educational Neglect	Unfounded	Yes
	Deceased Child, Male, 14 Years	Mother, Female, 40 Years	Educational Neglect	Unfounded	
	Sibling, Female, 13 Years	Mother, Female, 40 Years	Educational Neglect	Unfounded	
	Deceased Child, Male, 14 Years	Mother, Female, 40 Years	Educational Neglect	Unfounded	

Report Summary:
The SS was absent 22 days and the SC was absent 31 days since the start of school . As a result, the SS and SC were failing. Last year, the SS had 56 absences and the SC had 79 absences. The continuation of absences had impacted the children's education. The SM was aware of the issue and was unwilling to address it.

Determination: Unfounded | **Date of Determination:** 02/16/2015

Basis for Determination:
ACS unsubstantiated the allegation EdN for the SS and SC by the SM on the basis that the children were not going to school on their own volition. The children were disrespectful to the SM and had listened to her despite her insisting they go to school.

OCFS Review Results:
During the review, ACS made face-to-face contact with the SM, SC and SS. ACS entered timely progress notes, made collateral contacts with relatives, offered services and made referrals. ACS contacted the BF and attempted to involve him in the service planning; however, he did not make himself available for services. Follow-up with the SC and SS medical provider and schools were not observed. Necessary initial child safety conference (ICSC) was scheduled for 1/30/15; however, the documentation did not reflect it was held. ACS had knowledge of the children's daily drug use and the SC tested positive for marijuana. ACS did not appropriately address the children's drug misuse.

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

Issue:
Appropriateness of allegation determination
Summary:
ACS unsubstantiated the allegation of EdN although the findings reflected the children had excessive school absences, failed their classes and the SM did not take sufficient steps to set limits and follow up with their school in an effort manage the children's behavior.
Legal Reference:
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:
Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:
There was credible evidence for ACS to add and substantiate the CD/A allegation of the SC and SS by the SM. During the investigation, ACS was informed by the SM of the children's drug use and her inability or willingness to appropriately address their behavior. The children confirmed their daily drug use and the SC tested positive for marijuana.
Legal Reference:
SSL 412(1) and 412(2)
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:
Failure to provide notice of report
Summary:
ACS had not generated an NOE or documented that the NOE was provided to the identified BF.
Legal Reference:

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

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 Documentation of Safety Assessments

Summary:

There were safety factors identified during the ACS interviews with the SM, SC, SS. The safety assessment documents did not include nor address the identified safety factors surrounding the SM's supervision and expectations of the SC and SS.

Legal Reference:

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

Timely/Adequate Case Recording/Progress Notes

Summary:

The ACS case record did not reflect whether there was follow-up casework activity concerning the SC and SS's medical provider and schools. The Initial Child Safety Conference (ICSC) was scheduled for 1/30/15; however, the documentation did not reflect the ICSC was held.

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.

[redacted]

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

The family was known to the SCR and ACS in a report dated 10/26/07. The allegation themes were EdN and IG of the SC by the SM. ACS unsubstantiated all the allegations of the report on the basis of finding of no credible evidence.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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: 02/25/2017

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: 02/25/2017

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?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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:
Two agencies provided services to the family. On 4/19/17, JCCA begun service provision to the SM, SC and SS. On 1/19/18, JBCFS provided the SM and SS a higher level of services.

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The review revealed JCCA had nine untimely documented progress notes entered between 7/3/17 through 2/2/18.
Legal Reference:	18 NYCRR 428.5
Action:	JCCA 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.

Preventive Services History

On 12/4/07, the family had an opened Advocate-Preventive Only (ADVPO) service case with Graham-Windham Services. The family received family planning and educational planning services. The case was closed on 7/24/08.

As a result of the 11/13/15 investigation, ACS opened a service case on 12/27/15 as the SM agreed to accept PPRS. On 1/11/16, ACS and preventive service agency conducted a joint home visit; however, on 1/14/16 the service case was closed due to the SM's refusal to participate in the service plan implementation.

As a result of the 1/4/17 investigation, ACS opened a service case on 2/23/17. The JCCA agency had case planning responsibility. The family received case management and mental health services. The CP last visited the home on 11/28/17.

Casework Contacts

	Yes	No	N/A	Unable to Determine

Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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

Explain: The agency to follow-up on contacts to the BF and the children's school. Regular face-to-face and telephone contact with school personnel and relatives would have enhanced the assessment of the family. The communication would have allowed for an exchange of information that would create the opportunity to probe and obtain clarity of the family's service needs.