NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-044 **Prepared by: New York City Regional Office**

Issue Date: 11/28/2016

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 05/06/2016
Initial Date OCFS Notified: 05/06/2016

Presenting Information

The 5/6/16 SCR report alleged the 11-week-old female infant resided with the mother, aunt and two siblings. The report also alleged at about 5:00 AM on 5/6/16, the mother fed the infant and put her to sleep. The mother woke at 8:50 AM and found the infant was not moving or breathing. The mother called 911 and the infant was transferred to the Pediatric ER at Jamaica Hospital where the infant was pronounced dead at 9:25 AM. The infant was otherwise healthy and was possibly sleeping with the mother on the couch when it was noticed the infant was not breathing or moving. The cause of death was unknown. Due to the unknown cause of death and the uncertainty of where or when the infant was found not breathing, both the mother and aunt were alleged subjects of the report. The roles of the other two children in the household were unknown.

Executive Summary

The 2-month old SC died on 5/6/16. As of 11/7/16, NYCRO has not yet received the ME report. The preliminary autopsy findings listed the cause and manner of death as undetermined.

The 5/6/16 SCR report included the allegations of DOA/Fatality and IG of the SC by the SM and MA.

ACS found the SM and her children were in a friend's home on 5/5/16 when the SM consumed alcohol and her behavior became indicative of intoxication. The SM left the friend's home with her children at approximately 1:00 AM on 5/6/16. The SM and children arrived at the MA's home at approximately 2:00 AM. The half-sibling and sibling slept upstairs with the MA and the SC and the SM co-slept on the sofa. The SM fed the SC at approximately 5:00 AM and then the SM went to sleep alongside the SC on the sofa. At approximately 8:50 AM, the SM found the SC unresponsive, alerted the MA and called 911. EMS responded to the home and observed the SC lying in the supine position on the table, unconscious with limbs in rigor mortis. The SC was transported via EMS ambulance to the hospital and the SM was transported separately by FDNY. The SC arrived in the ER unresponsive and with cold skin. The ER staff efforts to provide CPR, emergency medication and intubation were unsuccessful; the SC's condition had not improved and was pronounced deceased at 9:25 AM.

The SM and her children had many family shelter placements and the family had been receiving PPRS services since 2015. ACS maintained ongoing contact with the PPRS agency and monitored the agency case planning transfer from Lower Eastside Family Union (LESFU) to Harlem Children's Zone (HCZ). On 4/25/16, the SM was discharged from the shelter for non compliance of the facility regulations and she had temporarily resided in the homes of the MA and PGM. On 5/3/16, the SM agreed to reside in the PGM's home with the children and ACS conducted an assessment of the PGM's home on 5/4/16. The SM and children were not present during the scheduled ACS home visit. The ACS staff and PGM contacted the SM. The SM was unaware ACS had delivered a portable crib for the SC to the PGM's home on 5/5/16 when the SM decided to return to the MA's home.

Initially, the SM denied she co-slept with the SC, consumed alcohol or was intoxicated. ACS interviews with relatives and the half-sibling revealed the SM’s initial statements were inconsistent with the circumstances

surrounding the SC's death.

ACS filed an Article Ten Neglect petition in the New York County Family Court (NYCFC) and the judge remanded the sibling and half-sibling to the care and custody of the Commissioner of ACS. These two children were placed in kinship foster care with the PGM on 5/11/16. The family received educational support and bereavement services while in the kinship placement. The SM was referred to bereavement, parenting and treatment services. The SM received weekly supervised visits at the Forestdale foster care agency and the BF received supervised visit by the PGM in the foster home.

On 8/17/16, ACS substantiated the allegations of DOA/Fatality, IG, IFCS, and PD/AM of the SC by the SM on basis that the SM was intoxicated when she cared for and knowingly co-slept with SC in an unsafe sleeping environment. ACS added to the report and substantiated the allegations of IG, IFCS and PD/AM of the sibling and half-sibling by the SM on the basis that the SM was intoxicated and demonstrated poor judgment as she cared for the children. The SM missed appointments, failed to ensure the half-sibling attended school regularly and exhibited unpredictable behaviors that resulted in the family's continuous homelessness. ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the MA as the MA was not a person legally responsible for the SC.

Due to PGM's violation of NYCFC orders, the children were transferred to a non-kinship home on 10/14/16. As of 11/7/16, the Forestdale agency has continued to monitor the children in the new foster home.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
N/A

Was the decision to close the case appropriate? Yes

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

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

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Review of CPS History
Summary:	ACS did not document the review of the subject MA's CPS history.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Failure to provide notice of report
Summary:	There was no documentation that a NOE was provided to the alleged BF of the half-sibling.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS did not enter several Investigative Progress Notes dated 5/17/16 within the required 30-Day timeframe.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	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 SCR report was dated 5/6/16. The 30-Day Fatality Report was approved on 6/30/16.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Diligence of Efforts
Summary:	ACS did not make diligent efforts to locate and contact the alleged BF or paternal relatives of the half-sibling.

Legal Reference:	NYCRR 430.12D
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The SCR report was dated 5/6/16. The 24-Hour Safety Assessment was approved on 5/9/16.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	During the 5/6/16 investigation, ACS did not document whether there was collateral contact with the SC nor the half-siblings' medical provider.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	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 SCR report was dated 5/6/2016. The 24-Hour Fatality Report was approved on 6/30/16.
Legal Reference:	CPS Program Manual, VIII, B.1, page 2
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timeliness of completion of FASP
Summary:	The Reassessment FASP was due on 6/17/16; however, it was approved on 8/24/16.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/06/2016 **Time of Death:** 09:25 AM

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

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? Yes
Time of Call: 08:50 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☒ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	58 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Other Child	Alleged Victim	Female	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)

LDSS Response

According to the record, on 5/6/16, EMS was dispatched at 8:50 AM and arrived at the home at 8:56 AM. EMS observed

the SC's skin was pale, cool and dry to the touch. EMS left the scene 9:07 AM. CPR was continued on the SC until EMS arrived at the hospital at 9:13 AM.

Upon arrival in the hospital, the ER staff found the SC's skin was cold. The ER staff provided CPR and emergency medication and intubation was attempted. However, there was no improvement in the SC's condition and the pupils remained fixed. There were no visible marks or bruises observed on the SC. The ER staff said on 5/3/16 the SC was seen in the ER because the mother complained that the SC had symptoms of illness. The attending Dr. prescribed medication and discharged the SC to the SM's care.

The attending Dr. observed the SC had no visible or suspicious signs of abuse on 5/6/16. The ER staff observed the SM in the ER and found she was distraught upon learning of the SC's death. The SM attempted to harm herself. The SM was admitted, prescribed medication and given a follow up appointment before her discharge to the PGM on 5/6/16.

ACS visited the subject MA's home on 5/6/16. ACS identified the MA's mother also resided in the home. ACS observed the home was cluttered and the family did not have any smoke or carbon monoxide detector. The sleeping accommodations and provisions were not adequate for the SC, sibling and half-sibling. According to the MA, the SM planned to reside at the PGM's home however, the SM sometimes stayed in her home since the family's discharge from the shelter on 4/25/16. The MA stated the SM appeared intoxicated when she arrived in the home with the three children at approximately 2:00 AM on 5/6/16. The MA's mother recalled she heard the SC cry around 5:00 AM and then heard the SM prepare the SC's meal in the kitchen. The MA and her mother confirmed the home did not have an appropriate sleeping arrangement for the SC.

According to the half-sibling, the family spent the day 5/5/16 at a friend's home. The half-sibling observed the SM drank three beers and acted differently during the period of time the family was in the friend's home. The half-sibling stated she fell asleep and the SM woke her up to leave the friend's home. She stated the SC and 3-year-old sibling remained asleep in a cab while the SM argued with the driver. The half-sibling confirmed the arrival time to the MA's home. The half-sibling said the SC slept on the sofa with the SM.

The family's Dr. confirmed the surviving children received immunization. There was no record that the SC had received immunizations.

ACS held an Initial Child Safety Conference (ICSC) with the SM and PGM on 5/9/16. ACS, SM and PGM discussed concerns regarding the surviving children due to the SM's inability to maintain stable housing, ensure the half-sibling regularly attended school, supervision of the children while intoxicated and the SM's need for professional treatment. ACS decided to file an Article Ten Neglect petition to request a remand of the surviving siblings to remain in the care of the PGM. ACS identified Credentialed Alcoholism and Substance Abuse Counselor (CASAC) assessment, treatment, medication monitoring services and supervised visits for the SM, and educational evaluation and monitoring, individual therapy and bereavement counseling for the surviving children.

On 5/10/16, ME's office informed ACS that a re-enactment was not completed due to the SM's unavailability. The ME found there was some hemorrhaging observed around the recent rib fracture the SC sustained and the ME staff concluded the SC's injury was sustained from receiving CPR. The ME staff stated the SM provided different statements regarding the SC's death to the Dr. and LE.

On 5/11/16, the NYCFC remanded the sibling and half sibling to the care and custody of the Commissioner of ACS.

As of 11/7/18, the family continued to receive services under the supervision of the Forestdale Inc. foster care agency.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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
029203 - Deceased Child, Female, 2 Mons	029206 - Aunt/Uncle, Female, 58 Year(s)	DOA / Fatality	Unsubstantiated
029203 - Deceased Child, Female, 2 Mons	029206 - Aunt/Uncle, Female, 58 Year(s)	Inadequate Guardianship	Unsubstantiated
029203 - Deceased Child, Female, 2 Mons	029208 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
029203 - Deceased Child, Female, 2 Mons	029208 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
029203 - Deceased Child, Female, 2 Mons	029208 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
029203 - Deceased Child, Female, 2 Mons	029208 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030381 - Sibling, Male, 3 Year(s)	029208 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
030381 - Sibling, Male, 3 Year(s)	029208 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
030381 - Sibling, Male, 3 Year(s)	029208 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030383 - Other Child - Half-sibling, Female, 6 Year(s)	029208 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
030383 - Other Child - Half-sibling, Female, 6 Year(s)	029208 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
030383 - Other Child - Half-sibling, Female, 6 Year(s)	029208 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
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:

Due to the SM's unavailability, a re-enactment could not be conducted by CPS or the ME.

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?	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
An Article Ten Neglect petition was filed in New York County Family Court. The sibling and half-sibling were paroled to the PGM. On 5/11/16, the Family Court remanded the surviving children to the care and custody of the Commissioner of ACS.

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/11/2016	There was not a fact finding	Article 10 Remand
Respondent:	029208 Mother Female 28 Year(s)	
Comments:	The surviving siblings were remanded to the care and custody of the Commissioner of ACS and placed in the kinship foster home of the PGM. The SM was ordered to have supervised visits at the foster care agency with the surviving siblings. According to CONNECTIONS records, the children were transferred to a different foster care home. A Family Services Progress Note (FSPN) dated 10/17/16 showed there had been safety concerns regarding the children's care in the PGM's home. According to the FSPN, the SM visited the PGM's home at a time supervised visits were required a the agency office, the SM slept in the PGM's home and took the half-sibling for an unsupervised visit. The BF visited the children unsupervised and regularly spent the night in the PGM's home. The FM left the children in the care of a family relative who was 18 years old although the FM had been informed that babysitters and back-up resource persons for the foster children must be at least 21 years old.	

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The BF filed for visitation and custody. The Family Court vacated the TOOP on 8/3/16. The BF was ordered supervised visitation with the surviving siblings at the FH home. The visits were to be supervised by the PGM.	

Have any Orders of Protection been issued? Yes	
From: 05/11/2016	**To:** 08/03/2016
Explain: The TOOP was issued concerning the sibling's BF. The BF was ordered to have supervised agency visits upon his release from jail on 6/19/16. On 8/3/16, the court vacated the TOOP and allowed the BF to have supervised visitation with the surviving siblings in the kinship foster home of PGM. The PGM agreed to supervise the visits.	

Services Provided to the Family in Response to the Fatality

Services	Provided After	Offered, but	Offered, Unknown	Needed but not	Needed but	N/A	CDR Lead to

	Death	Refused	if Used	Offered	Unavaliable		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	☒	☐	☐	☐	☐	☐	☐
Other, specify: supervised visitation							
Additional information, if necessary: The SM refused participation in bereavement services offered by ACS and other services by the foster care agency.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The family received Early Intervention, case management, child care, health, housing, medical and education related services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Upon the SM's arrival in the hospital and learning of the SC's demise, the SM attempted to publicly harm herself. The SM was immediately evaluated by hospital staff, provided medication and a follow-up appointment at the hospital for 5/10/16 before she was released to the PGM.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? 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

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/04/2016	10322 - Other Child - Half-sibling, Female, 6 Years	10311 - Mother, Female, 27 Years	Inadequate Guardianship	Unfounded	Yes
	10322 - Other Child - Half-sibling, Female, 6 Years	10311 - Mother, Female, 27 Years	Educational Neglect	Indicated	
	10351 - Sibling, Male, 3 Years	10311 - Mother, Female, 27 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 2/4/16 report alleged the SM had a history of "mental health issues,"and had not addressed the issues. The SM was the sole caretaker for the children ages six and three years old. There was concern for the children because the SM was unreachable. The 6-year-old half-sibling's school attendance rate was 58% and there was a need for an evaluation. The SM was non compliant. The SM was verbally abusive to the half-sibling and belittled the half-sibling on a regular basis. The SM was receiving services and was not reachable.

Determination: Indicated | **Date of Determination:** 04/06/2016

Basis for Determination:
ACS substantiated the allegation of EdN of the half-sibling by the SM. ACS gathered credible evidence from the school to support the allegation. The half-sibling had excessive absences that caused her to have a doubtful promotion to the

next grade.

ACS unsubstantiated the allegation of IG of the sibling and half-sibling on the basis that ACS staff observed the children's basic needs were up to date and the SM provided the children with appropriate sleeping arrangements, food, clothing and the minimum degree of care.

OCFS Review Results:
ACS made diligent efforts to engage the SM. ACS made significant and relevant collateral contacts with the medical, school, DHS staff and preventive service caseworker to gather credible evidence.

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

Issue:
Failure to provide notice of report

Summary:
There was no documentation that the BF of the sibling or the alleged BF of the half-sibling were provided a Notice of Existence (NOE).

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
ACS did not enter some of the Investigation Progress Notes within the required 30-day timeframe. Some of the casework activities dated 2/29/16, 3/1/16, 3/4/16 were entered until 4/5/16.

Legal Reference:
18 NYCRR 428.5(a) and (c)

Action:
ACS must submit a corrective action plan 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:
Predetermination/Assessment of Current Safety and Risk

Summary:
The Risk Assessment Profile included inaccurate information about the family's housing condition, history of domestic violence, and the SM's expectations and ability to address the half-sibling's educational needs.

Legal Reference:
18 NYCRR 432.1(aa)

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR	Alleged	Alleged	Allegation(s)	Status/Outcome	Compliance

Report	Victim(s)	Perpetrator(s)			Issue(s)
11/02/2015	10081 - Sibling, Male, 2 Years	10371 - Father, Male, 26 Years	Inadequate Guardianship	Unfounded	Yes
	10081 - Sibling, Male, 2 Years	10082 - Mother, Female, 26 Years	Inadequate Guardianship	Unfounded	
	10081 - Sibling, Male, 2 Years	10082 - Mother, Female, 26 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:
The 11/2/15 SCR report alleged the SM had a history of hitting the 2-year-old sibling. In mid-September 2015, the SM got mad at the sibling and hit him and caused him to fall off the bed where he sustained a bump to his head. Most recently, the SM hit the sibling in the face causing the sibling to bite the inside of his bottom lip. As a result, the sibling was missing skin from the area. The BF was aware of the injury; however, the BF told the sibling that he had fallen. The role of the 6-year-old half-sibling was unknown.

Determination: Unfounded | **Date of Determination:** 12/03/2015

Basis for Determination:
ACS unsubstantiated the allegations of IG and L/B/W of the 2-year-old sibling by the SM. The SM was directed to send the sibling to the hospital. The sibling provided inconsistent statements and the marks observed on the sibling were consistent with the SM's statement. The hospital staff stated the sibling appeared healthy and a bruise on the lip was observed that may have been from an incident or an accidental fall. The allegation of IG of the sibling by the BF was unsubstantiated due to insufficient evidence. ACS made several unsuccessful attempts to contact the BF.

OCFS Review Results:
The results of this review showed ACS entered timely progress notes, made diligent efforts and pertinent casework and collateral contacts with schools and medical staff. There was sufficient and relevant face-to-face casework contact with the parent, sibling and half sibling.

On 11/10/15, the Family Services Stage was opened to provide the family with PPRS. The Lower East Side Family Union (LESFU) was assigned case planning responsibility.

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

Issue:
Provide preventive services according to the needs of the child and the child's family

Summary:
ACS referred the family to a PPRS agency that was not suitable for the family's need for intensive services. The SM verbalized the need for more supervision and the PPRS agency informed ACS that the agency was not an appropriate provider for the family's needs.

Legal Reference:
18 NYCRR 423.4(a); SSL 424 (13)

Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citation identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

The SM was known to the SCR and ACS in four reports dated 11/17/09, 6/14/10, 4/18/11 and 12/19/2013.

The 11/17/09 and 2/19/13 reports included the allegation of IG of the half-sibling by the SM. ACS unsubstantiated the allegation of IG of the half-sibling by the SM. The 11/17/09 and 2/19/13 reports were unfounded and closed. There were no service referrals resulting from the investigations.

The 6/14/10 report included the allegations of IG, L/B/W and S/D/S of the half-sibling by her alleged father. The SM was listed as the Non-Confirmed Subject. ACS substantiated the allegations of IG and L/B/W of the half-sibling by her alleged father on the basis that he physically attacked the SM and hit the half-sibling during the altercations. ACS noted that the half-sibling sustained marks and bruises. ACS opened the Family Services Stage (FSS) of the case on 8/9/10 and the family received PPRS.

On 4/18/11, the services case was open when the SCR registered a report including the allegation of IG of the half-sibling by the SM. ACS findings showed the SM had a history of substance abuse, involvement in domestic violence incidents, unstable housing and non-compliance with prescribed treatment. ACS substantiated the allegation of IG of the half-sibling by the SM.

The 4/18/11 report was indicated. ACS closed the investigations stage of the report and the case remained open for PPRS.

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: 11/10/2015

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: 11/10/2015

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

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐

If not, how many days was it overdue? The most recent FASP was due on 6/17/16 however it was approved on 8/24/16 by the FCA.				
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: The FSS stage was opened and the family received PPRS with the LESFU agency.				

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 Family Services Progress Notes showed there were casework activities that were not entered within the required 30- day timeframe.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must request a corrective action plan from the LESFU agency within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Preventive Services History

As a result of the indicated 4/18/11 investigation, ACS found the family required services to support family functioning. The HCZ and Episcopal Social Services agencies had case planning responsibilities during separate periods of time. The

Family Services Progress Notes (FSPN) showed that the SM did not made herself available nor follow through with the service plan goals. Subsequently, the PPRS case was closed 12/11/12.

ACS opened the case for services on 11/10/15 the LESFU agency provided PPRS. The SM continued to be unavailable and unable to participate in service with LESFU. The SM relocated to three different shelter placements due to her inability to cooperate with the shelter mandates. The CP made adequate family casework and collateral contacts at each shelter placement. The SM attended an Elevated Risk Conference (ERC) on 3/24/16. The CP documented that there were no safety concerns regarding the children when a successful HV was conducted on 4/1/16. The SM was not present for the scheduled joint home visit with LESFU CP and HCZ on 4/27/16. The FSPN showed the shelter staff stated the SM relocated to whereabouts unknown. Later, ACS and LESFU agency learned that the SM had been visiting the MGM's home. ACS staff visited the MGM's home on 5/5/16 and interviewed the MGM who said she did not have updated information about the SM's whereabouts.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☒Yes ☐No

Issue:	Timeliness of completion of FASP
Summary:	The FASP was due on 6/17/16; however, it was approved on 8/24/16.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must request a corrective action plan from the Forestdale agency within 45 days that identifies the action the agency will take or has taken 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.

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** 01/29/2016
Explain: An Order of Protection expired against the BF with an unknown victim.	

From: 03/02/2015	**To:** 03/03/2016
Explain: An Order of Protection expired against the BF with an unknown victim.	

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