Child Fatality Report

Report Identification Number: NY-19-040

Prepared by: New York City Regional Office

Issue Date: Oct 04, 2019

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: 0 day(s)
Jurisdiction: New York
Gender: Male
Date of Death: 05/02/2019
Initial Date OCFS Notified: 05/02/2019

Presenting Information

On 5/2/19, the SCR registered a report alleging the mother gave birth to a male child and failed to seek medical attention. The report stated the mother discarded the body of the SC in a garbage can and the SC's umbilical cord was not clamped. The report stated the SC bled out through the umbilical cord and was pronounced dead at 7:00 P.M. at Lincoln Hospital. The report stated the preliminary cause of death was listed as cardiac arrest.

Executive Summary

On 5/2/19, the 14-year-old mother gave birth to a male child in the home of her friends and then wrapped the SC up and took the SC out to the street and placed him in the garbage. The mother reported the SC did not cry at delivery; however, the results of an autopsy report is pending to confirm whether this was a stillborn delivery.

On 5/2/19, the SCR registered a report regarding the death of the SC with allegations of DOA/FATL, AB, LMC, and IG of the SC by an unknown subject. Shortly after, the NYPD identified the mother as the person who discarded the SC's body.

At the time of the incident, the mother was listed as a MA in a report dated 3/25/19. The allegations of the report were: EdN, LS, LMC, and IG of the mother by the MGM and EdN by a PS.

ACS initiated the investigation timely and contacted the NYPD who identified the SC's parents. ACS conducted joint interviews with the NYPD which included medical staff, parents, MGM, PGM, MU and the friends with whom the mother was staying at the time of the incident. According to the interviews, no one knew of the mother's pregnancy. It was confirmed the mother had no other children.

On 5/7/19, ACS held a Child Safety Conference with the MGM to discuss safety concerns for the mother as a child.

Based on the mother's age, on 5/8/19, ACS filed an Article 10 Neglect Petition at the Bronx County Family Court (BxCFC) against the MGM on behalf of the mother. The mother was removed from the MGM's care. Over ACS' objection, the judge released the mother to her friends' parents where the incident occurred.

As of the writing of this report, the NYPD maintained an open investigation pending the results of the autopsy. Therefore, ACS had not made a determination.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**

- **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The determination is pending the autopsy results to determine whether or not this was a still born as reported by the mother.

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/02/2019 **Time of Death:** 07:00 PM

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

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

Did child have supervision at time of incident leading to death? 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	Aunt/Uncle	No Role	Male	17 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	0 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	14 Year(s)

LDSS Response

ACS made relevant collateral contacts and worked closely with the NYPD and the ME after learning the identity of the SC's parents.

According to the NYPD, a passerby stopped them at about 6:29 P.M. and reported he saw something strange by the garbage where the mother's friends resided and called 911. EMS responded by 6:40 P.M. and transported the SC to Lincoln Hospital where they arrived at about 6:44 P.M. Resuscitation efforts failed and the SC was pronounced dead at 7:00 P.M.

According to the medical staff, the SC was estimated to have been born between 36-38 weeks gestation; and weighed 6 pounds and 1 ½ ounces. The medical staff reported the mother had a flat affect and was detached. Therefore, the mother was admitted to the hospital overnight due to postpartum delivery, and for a clinical evaluation. The mother was diagnosed with "adjustment disorder due to stillborn." However, the ME did not confirm this was a stillborn delivery. The mother was discharged from the hospital on 5/4/19 and went to stay temporarily with a relative.

ACS intended to place the mother in the care of the relative, but the relative declined as she had her own children and did not feel she could handle the responsibilities to care for the mother. The MGM did not respond to the court dates; therefore, the mother remained in the care of her friends' parents.

According to the mother, on 5/1/19 she was staying at her friends' home and no one in the home was aware of her pregnancy, delivery, or the disposal of the SC's body. The mother said at about 2:00 A.M. she began having back and stomach pain, and was unable to fall asleep. The mother said she thought she had food poisoning from some take out food she had eaten earlier. The mother said her friends' parents gave her Pepto Bismol milk, ginger ale, and prune juice to make her feel better. The mother said at about 3:00 A.M., she felt the need to use the bathroom. When she sat on the commode, her water broke and she delivered the SC while sitting on the commode. The mother said she picked up the SC, and cut the umbilical cord with scissors she found in the bathroom, and then flushed the placenta. The mother said she held the SC close to her chest, but he had no heartbeat and did not look alive. The mother said she washed his head with soap; and he made no movement, so she took him to the room where she was staying and placed him on the bed. The mother said the SC's eyes were closed; he was not breathing, and did not respond to her touch. The mother said her friends' father went to use the bathroom and she told him the bathroom was a mess because she had a bad period. The mother said she discreetly took the SC out and placed him on top of a trash can located in the back of the building. The mother stated she felt guilty and was afraid. ACS interviewed the friends' parents and they denied knowing of the mother's pregnancy.

ACS interviewed the PGM and the 16-year-old father who reported they were not aware the mother was pregnant or that she was at the hospital.

The ME requested a deoxyribonucleic acid (DNA) test from the mother before the body can be released to her, but the mother has not followed up.

As of the writing of this report, ACS has not made a determination.

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: There was no documentation of an MDT investigation; however, the investigation adhered to previously approved protocols for joint investigation.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051151 - Deceased Child, Male, 0 Days	051154 - Mother, Female, 14 Year(s)	Lack of Medical Care	Pending
051151 - Deceased Child, Male, 0 Days	051154 - Mother, Female, 14 Year(s)	DOA / Fatality	Pending
051151 - Deceased Child, Male, 0 Days	051154 - Mother, Female, 14 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

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

Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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:**
05/08/2019	There was not a fact finding	There was not a disposition
Respondent:	051152 Grandparent Female 32 Year(s)	
Comments:	After the fatality, the MGM did not take responsibility of the 14-year-old and ACS filed an Article 10 against the MGM and placed the mother in the home of her friends where she had been staying prior to the fatality.	

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
The SC had no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The mother was a minor and the MGM did not respond as a support for her after the fatality. ACS filed a Neglect Petition and was granted a remand. Family Court placed the mother with her friends' parents.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/25/2019	Other Child - MU in the Fatality report, Male, 17 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	Yes
	Other Child - Mother of the fatality report , Female, 14 Years	Mother, Female, 32 Years	Educational Neglect	Substantiated	
	Other Child - Mother of the fatality report , Female, 14 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Other Child - Mother of the fatality report , Female, 14 Years	Mother, Female, 32 Years	Lack of Medical Care	Substantiated	
	Other Child - Mother of the fatality report , Female, 14 Years	Mother, Female, 32 Years	Lack of Supervision	Substantiated	
	Other Child - Mother of the fatality report , Female, 14 Years	Other Adult - Former guardian of the 14 year old, Female, 59 Years	Educational Neglect	Unsubstantiated	

Report Summary:
The SC in this report is the 14-year-old mother listed in the fatality investigation.

On 5/24/19, the SCR registered a report with the SCR stating the SC had been absent from school 44 days and late 72 days for the school year of 2018-2019, and as a result the SC was failing. The report alleged the mother was aware of the SC's excessive absences, but failed to address the problem.

The report referred to the SC's former guardian as the mother, ACS learned the SC's school record had not been update.

Report Determination: Indicated | **Date of Determination:** 05/24/2019

Basis for Determination:
ACS substantiated the allegations of EdN, LS, and LMC of the SC by her mother. ACS based their decision on the SC's poor attendance and the mother's failure to respond to the school staff, the mother failed to properly supervise the SC who frequently stayed with her boyfriend and friends overnight, and smoked marijuana. The mother also failed to obtained medical care for the SC who was pregnant and the mother had no knowledge.

ACS substantiated the allegation of IG of the SC and her sibling by the mother as she failed to provide for their basic needs.

The allegation of EdN of the SC by her former guardian was unsubstantiated as she was no longer a PLR for the SC.

OCFS Review Results:
ACS initiated and completed an adequate and timely investigation. ACS assessed the safety of the SC in practice, but based on the documentation of the safety assessment, the instrument was not adequately completed. All notices were issued for the subjects of the report. The mother did not have any interest in the care of the SC and did not respond to the SC's needs or ACS' efforts to engaged the family in services. Therefore, ACS filed and Article 10 Neglect Petition on behalf of the SC and was granted a remand.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
ACS made adequate safety decisions; however, did not respond properly to all aspects of the instrument.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/12/2018	Other Child - Mother of the fatality report , Female, 14 Years	Mother, Female, 31 Years	Emotional Neglect	Substantiated	Yes
	Other Child - Mother of the fatality report , Female, 14 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Other Child - Mother of the fatality report , Female, 14 Years	Mother, Female, 31 Years	Lacerations / Bruises / Welts	Substantiated	
	Other Child - Mother of the fatality report , Female, 14 Years	Other Adult - Former guardian of the 14 year old, Female, 59 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Mother of the fatality report , Female, 14 Years	Other Adult - Former guardian of the 14 year old, Female, 59 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The 13-year-old SC in this report is the mother listed in the fatality investigation.

The SCR registered a report alleging the 13-year-old SC was hit in the eye by her former guardian (FG) with a shoe for unknown reasons. The SC sustained bruising under her right eye as a result of the FG's actions.

ACS learned the 13-year-old had been in the care of her FG until 2017; however, at the time of this report she was in the care of her mother.

Report Determination: Indicated | **Date of Determination:** 11/09/2018

Basis for Determination:
ACS unsubstantiated of L/B/W and IG on the SC by the FG as it was determined the FG was no longer a PLR.

ACS substantiated the allegations of L/B/W, EM, and IG of the SC by the mother. ACS cited the mother admitted to throwing a shoe at the SC during an argument and as a result the SC sustained the bruises. Also, the SC had been absent 46 times and late 108 times for the school year of 2017-2018 and was exhibiting the same pattern during the current school year. In addition, the mother refused to wake up the SC to send her to school or to work with the school staff to refer the SC for counseling services.

OCFS Review Results:

The safety decisions selected in the safety assessments were appropriate; however, the documentation reflected a lack of understanding on how to complete the instrument. The comments to support the safety factors were not concise, all safety factors were not included and/or there was no reliable safety plan established when necessary. ACS was made aware the SC had a history of self-mutilation, but did not make an effort to contact her pediatrician to properly address this issue.

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

Issue:

Timely/Adequate Seven Day Assessment

Summary:

ACS did not select all the safety factors present nor provided clear and concise comments to support those safety factors that were selected.

Legal Reference:

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

Action:

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

Issue:

Failure to Provide Notice of Indication

Summary:

The Notices of Indication were not issued to any of the subjects of the report.

Legal Reference:

18 NYCRR 432.2(f)(3)(xi)

Action:

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

ACS selected a safety decision that noted the SC was in need of a safety plan, but none was put in place. Also, all relevant safety factors were either not included or did not have clear comments to support the safety factors selected.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/17/2017	Other Child - Mother of the fatality report , Female, 13 Years	Aunt/Uncle, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - MU in the Fatality report, Male, 16 Years	Aunt/Uncle, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Mother of the fatality report , Female, 13 Years	Grandparent, Female, 57 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - MU in the Fatality report, Male, 16 Years	Grandparent, Female, 57 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Mother of the fatality report , Female, 13 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - MU in the Fatality report, Male, 16 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Mother of the fatality report , Female, 13 Years	Aunt/Uncle, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - MU in the Fatality report, Male, 16 Years	Aunt/Uncle, Male, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Mother of the fatality report , Female, 13 Years	Grandparent, Female, 57 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - MU in the Fatality report, Male, 16 Years	Grandparent, Female, 57 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Mother of the fatality report , Female, 13 Years	Grandparent, Female, 57 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - MU in the Fatality report, Male, 16 Years	Grandparent, Female, 57 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Report Summary:
The children in the report were the mother (12) and the MU (15) listed in the fatality. The report alleged the uncle sold marijuana from the home and he smoked marijuana with up to 20 people in his room. The report alleged the MGM also participated in the drug use, and did not properly care for the children. The report alleged the MGM did not cook regularly for the children and as a result they would at times go without eating. The report stated the mother was unable to intervene and this situation occurred on an ongoing basis.

The investigation revealed the uncle smoked in the home; but, the mother, uncle, and the MGM reported he did not do so in the children's presence.

Report Determination: Unfounded

Date of Determination: 12/16/2017

Basis for Determination:
ACS unsubstantiated the allegation of PD/AM and IG of the children by the uncle as it was determined he was not a person legally responsible (PLR).

ACS unsubstantiated the allegation of IF/C/S, PD/AM, and IG of the children by the MGM because she was providing all their basic needs; and always appeared alert and coherent during visits.

ACS unsubstantiated the allegation of IG of the children by the mother because their needs were being met, and whenever any issue arose the mother addressed it.

OCFS Review Results:
The investigation was not thorough as safety assessments were either not completed properly or did not consider the information gathered to select the safety decisions and/or safety factors. In addition, ACS had some credible evidence to indicate the report, but did not do so. It was evident the 12-year-old lacked proper supervision, had difficulty in school with her attendance and academic performance; and was verbally and emotionally abused by the MGM. It was reported the 12-year-old had a medical condition; however, this was not explored. The mother and the MGM had a strained relationship; yet, the mother would leave the children with the MGM without the MGM agreeing to care for them

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
ACS selected the family's history as a safety factor, but did not provide details of patterns/trends. Instead, a summary of the casework activity was documented.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue..

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
ACS did not properly follow up with the information provided by the family as the mother said that she would sometimes take the 12 year old to stay with her, but did not explore/assess where the SC stayed when she was not at the MGM's home.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
ACS' safety decision reflected there were no safety concerns, which was not consistent with the information gathered. The 12-year-old SC was staying out late, not coming home, and had academic and attendance problems at school. It was evident the MGM had no control over the SC's behavior and the mother seemed unwilling or unable to care for the SC.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination
Summary:

ACS unfounded the report without considering the information gathered. The mother left the 12-year-old SC with the MGM without establishing an agreement, knowing the MGM was verbally abusive towards the SC. Also, the MGM had thrown water and condoms at the SC. In addition, the SC had special educational needs and was not attending school regularly or doing well academically.

Legal Reference:

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

Action:

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

ACS made numerous contact via fax. ACS did not interview family members mentioned in investigation, neighbors, the mother's boyfriend, additional school staff to further explore and/or address the problems of the 12-year old SC. The collaterals did not focus on each of the subjects.

Legal Reference:

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

Action:

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

[redacted]

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

The family had no CPS history during this period.

Known CPS History Outside of NYS

The family had no known CPS history outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No