Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-033

Prepared by: New York City Regional Office

Issue Date: Sep 29, 2017

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 03/31/2017
Initial Date OCFS Notified: 03/31/2017

Presenting Information

The 3/31/17 SCR report alleged the 1-year-old SC was sick for the past 1-2 days. The SF failed to bring SC for medical attention or give the SC medication. On 3/31/17, the SC drank a bottle of milk and began to vomit and shake. The SF called 911 and the SC was in cardiac arrest when EMS arrived. The SC was pronounced dead at 12:47 PM. The SC was otherwise healthy with no preexisting medical conditions and there was no explanation for the cause of her death at the time. The SF had custody of the SC and it was unknown how much contact the BM had with the SC. 911 was called at 11:56 AM and the SC was pronounced dead at 12:47 PM. The SC was the only child in the home. The SF and SC were residing in a shelter. The room looked clean and well kept. The SC was last observed alive by the SF. The SC's body was viewed at the Elmhurst Hospital with no sign of injury.

Executive Summary

This 1-year-old female SC died on 3/31/17. The 3/31/17 report included allegations of DOA/Fatality, IG and LMC of the SC by the SF. On 4/5/17, the SCR received a subsequent report with the allegation of P/Nx. ACS investigated the reports simultaneously.

According to the ME, no injuries were observed on the SC's body. As of 9/14/17, NYCRO had yet to receive the ME's report.

ACS interviewed the SF regarding the circumstances surrounding the SC's death. The SF said the SC was otherwise healthy and her immunizations were up to date. The SF stated the SC's cough began on 3/29/17. The SF monitored the SC's cough throughout the day. On 3/30/17, the SF observed the SC's behavior was normal, but still had a slight cough during the day. Towards nightfall, the SC's cough worsened. Around 12:30 PM, the SF informed the shelter staff the SC was sick and required medicine. The staff told the SF the SC's condition would not improve if the SF took the SC out in the rain. The SF said he asked the staff to supervise the SC so he could go obtain medicine for the SC, to which they declined. The SF said he returned to his room and continued to care for the SC. The SF said the SC's cough appeared to lessen after time passed. He placed the SC on her back in her crib and she slept through the night. The SF denied the SC had a fever.

On 3/31/17, the SF woke up around 10:30 AM and the SC woke up alert with a slight cough. The SC drank a bottle of milk and moments later, the SC began coughing. The SF picked up the SC and patted her back; however, she continued to cough and began to cry. Suddenly, the SC began to gag; the SF immediately alerted someone of his need for help. A shelter resident entered the room and observed the SC was coughing and gagging as another resident called 911. While on the phone with the 911 operator, the SF said the SC appeared to have had a seizure. The 911 operator instructed the SF to turn the SC to her side. The SF did as he was instructed. The SC's eyes closed and she became unresponsive. Shortly thereafter, the paramedics arrived and performed CPR on the SC. EMS escorted the SC via ambulance to the hospital while the SF was interviewed by NYPD. The SF was escorted to the Elmhurst Hospital by NYPD; shortly thereafter, the SC died at 12:47 PM.

The SF's earlier statements were inconsistent. Later, the SF stated on 3/31/17 at approximately 12:30 AM the SC was ill when he asked the shelter staff for permission to leave the shelter and the staff informed the SF that the family would be discharged if he left shelter after the curfew.

The SF and SC were evicted from their apartment which resulted in their initial placement with the Department of Homeless Services in February 2017. The SC shared a one-bedroom unit with the SF at several city shelters until her death. The family was found ineligible for housing due to the SF's inability to provide the required documentation within the specified timeframe.

On 7/10/17, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the SF as there were findings of credible evidence that the SF failed to acknowledge the SC's symptoms, seek medical attention and provide a safe environment; which collectively lead to the SC's death. The SF admitted he did not obtain treatment for the SC's symptoms, missed medical appointments for the SC and he smoked marijuana. The allegation of P/Nx was unsubstantiated as there was no evidence of such as the Dr. said the SC had a viral infection in her lungs.

As of 8/23/17, there were no children in the care of the SF. ACS made attempts to engage the SF; however, the SF ceased further communication with ACS and his whereabouts were unknown. The Family Services Stage (FSS) remained opened due to the BM's two older children being placed in kinship foster care in 2014.

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?** 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:
There were no SS in the home or in the care of the SF or BM.

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:
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Required Actions Related to the Fatality

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

Child Fatality Report

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 received on 3/31/17. The 24-hour Fatality Report and the corresponding safety assessment were approved on 4/4/17 and 4/3/17, respectively; therefore, the approvals did not occur within the specified timeframe.
Legal Reference:	CPS Program Manual, VIII, B.1, page 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/31/2017 **Time of Death:** 12:47 PM

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: 11:55 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Other Household 1	Mother	No Role	Female	23 Year(s)

Other Household 2	Other Child - Half-sibling	No Role	Female	9 Year(s)
Other Household 2	Other Child - Half-sibling	No Role	Female	7 Year(s)
Other Household 3	Other Child - Half-sibling	No Role	Female	8 Year(s)

LDSS Response

On 3/31/17, LE received a 911 call at 11:55 AM, stating that the SC was in distress and had been taken to the hospital via ambulance. The SF was questioned by LE and escorted to the hospital. LE stated the room was observed as neat, clean and free of foul odor. The SF was cooperative with questioning regarding the SC. LE learned that the ME's preliminary autopsy result showed the SC died of natural causes. No arrests were made and the criminal investigation was closed.

The ACS Specialist interviewed the ER personnel who said EMS continued CPR on the SC en-route to the ER. Upon EMS' arrival to the hospital, the SC had no pulse and was unresponsive. The Dr. stated the SC died shortly thereafter. The SC had no visible signs of injuries or trauma to the body. The Dr. had not observed any suspicious behaviors or signs to indicate the SF was under the influence of any substance.

According to the ME, there were no injuries observed on the SC's body during the autopsy. The preliminary test result revealed the SC was sick and did not die from anything suspicious.

The shelter staff said the SF and SC arrived at the shelter on 3/29/17 at 3:30 AM. An intake meeting was scheduled on 3/30/17; however, the SF had a meeting with the EI provider. The intake was rescheduled to 3/31/17 at Noon. On 3/31/17, about 11:54 AM, a resident alerted the staff that the SF required help. The SC was observed with blue lips. The room temperature was hot and smelled of a mixture of marijuana and cigarettes. The staff closed the room to allow for the ME and LE investigation.

On 4/4/17, the Specialist interviewed the SF via telephone. The SF said that he and the BM were told that the SC died of natural causes. The SF said the SC received immunizations earlier in the year. The SF admitted he missed two medical appointments for the SC; one in late February 2017 due to the family's return to PATH: the reason for the second missed appointment in March was unclear. The SF admitted the room was warm as he kept the portable heater setting at 75 degrees; therefore, he was surprised the SC had an increased temperature. The SF said the heater was placed "quite a distance" from his bed and the SC's crib as a safety precaution. The SF denied he harmed the SC and said he took care of his SC the best he could.

According to EMS personnel, the SC had a temperature of 105 degrees when EMS arrived in the home. The SC was not observed with any marks or bruises and she appeared to be clean. There was no smell of cigarettes or marijuana in the room. The room appeared to be clean and neat.

On 4/5/17, EI provider stated the SC's interaction with SF was observed on 3/30/17. The reason for the SC's referral was due to concerns the SC was not meeting developmental milestones. The provider did not smell cigarettes or marijuana in the home. The SF appeared alert, clean and not under the influence of any substances. The SC did not appear sick or cough during the visit. There were no safety concerns regarding the care the SF provided to the SC.

On 4/6/17, ACS offered burial and bereavement services to the parents. It was unclear if the services were accepted.

On 5/24/17, ACS contacted the assigned family services unit (FSU) worker. The worker had experienced difficulty visiting the family as the family was frequently replaced in different shelters. The SC was last seen on 3/21/17 and appeared well. The worker was unaware of the SF and the BM's whereabouts since the SC's death.

On 5/31/17, ACS conducted a HV to assess the 8-year-old half-SS and the other children in the home. All the children appeared to have received adequate care. The BM of the half-SS acknowledged receipt of the bereavement referral ACS sent on 5/22/17 for the half-SS.

On 6/9/17, ACS held an Initial Child Safety Conference (ICSC) with only ACS staff present. The reason for the conference was unclear as the whereabouts of the parents were unknown and there were no children in the parents' care.

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
038381 - Deceased Child, Female, 1 Yrs	038382 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
038381 - Deceased Child, Female, 1 Yrs	038382 - Father, Male, 30 Year(s)	Lack of Medical Care	Substantiated
038381 - Deceased Child, Female, 1 Yrs	038382 - Father, Male, 30 Year(s)	DOA / Fatality	Substantiated
038381 - Deceased Child, Female, 1 Yrs	038382 - Father, Male, 30 Year(s)	Poisoning / Noxious Substances	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

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

Fatality Safety Assessment Activities

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

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	Needed but not Offered	Needed but Unavaliable	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:
There were no other children in the household or in the care of the SF and BM.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were offered services. The parents ceased communication with ACS and their whereabouts were unknown.

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?	Yes
Was the child acutely ill during the two weeks before death?	Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/20/2017	Deceased Child, Female, 1 Years	Father, Male, 30 Years	Inadequate Guardianship	Indicated	Yes

Report Summary:
The 3/20/17 SCR report alleged the SF had a female guest at his residence. During that time, the SF got into a physical altercation with the woman. The SC was in the crib in the same room and the SC witnessed the altercation.

Determination: Indicated | **Date of Determination:** 05/19/2017

Basis for Determination:
The allegation of IG of the SC by the SF was substantiated on the basis there was credible evidence found that the SC was present when the SF smoked marijuana and engaged in an altercation in the room. On multiple occasions the SF was found ineligible by the shelters as he had not provided the required documentation that resulted in multiple shelter relocations. The SF was uncooperative and did not provide ACS with the medical provider information for the SC as she was observed not meeting developmental milestones.

OCFS Review Results:

During the review, the subject was provided the notification of the report and determination, the required safety assessments were completed within the specified timeframes. The local protocol screening for DV and drug assessment was completed and the progress notes were entered timely. The BM was not provided the notifications of the report or determination, the 7-Day safety assessment did not identify the safety factors that placed the SC in immediate danger of serious harm to support the safety decision.

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

Issue:
Failure to provide notice of report

Summary:
Although not a subject of the report, the BM was not provided a NOE or a NOI.

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 7-Day safety assessment did not select or identify the safety factors that placed the SC in immediate danger of serious harm to support the safety decision.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/26/2016	Deceased Child, Female, 1 Years	Father, Male, 30 Years	Inadequate Guardianship	Indicated	Yes

Report Summary:
On 11/26/16, the SCR report alleged that on an ongoing basis the SF hit the 1-year-old SC on her hands and feet violently as a form of discipline. It was unknown if the SC had sustained any injuries. The BM's role was unknown.

Determination: Unfounded | **Date of Determination:** 01/25/2017

Basis for Determination:
ACS unsubstantiated the allegations on the basis there were no bruises or injuries observed on the SC during the face-to-face home visits. ACS found no evidence to support the allegation of XCP of the SC by the SF. The SF was referred to PPRS.

OCFS Review Results:
The DV and drug assessment local protocol was completed. The primary and secondary caregivers were incorrectly identified as well as the RAP responses in the areas of housing, financial resources, DV and caretaker's appropriate expectations of the child.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The review revealed ACS incorrectly identified the primary caregiver, made inaccurate and unsupported responses to selections on the RAP regarding the parents' housing, finances, DV and mental health history.
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:
Failure to provide notice of report
Summary:
The progress notes dated 11/28/16 stated the parents were provided a notice of report; however, the note did not state how the notice was delivered. The stage events show the NOE for both parents were generated on 12/15/16; however, not within the required timeframe. It appeared that ACS generated NOI for both parents on the same date in error.
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:
Required data and official documents
Summary:
Although the documentation reflects ACS requested the criminal record background check and DIR history of the parents from the investigative consultant (IC), the results of the inquiry were not documented in the progress notes to support the BM's account on the DV protocol and RAP.
Legal Reference:
428.3(b)(2)(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:
Adequacy of case recording
Summary:
During the investigation, there was a the lack of details regarding the parents' DV, MH and SA history, the impact on the SC and parents' need for referrals and consultation.
Legal Reference:
18 NYCRR 428.5(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)
09/16/2016	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Lacerations / Bruises / Welts	Unfounded	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Malnutrition / Failure to Thrive	Unfounded	
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Lacerations / Bruises / Welts	Unfounded	
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Lack of Supervision	Unfounded	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Lack of Supervision	Unfounded	
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Malnutrition / Failure to Thrive	Unfounded	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Lack of Medical Care	Indicated	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Lack of Medical Care	Indicated	
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:
The 9/16/17 SCR report alleged the SF was physically abusive towards the BM in the presence of the 1-year-old SC. It was unknown if the SC had sustained injuries during the incident. The SF had been sexually and physically abusive towards the BM during their two-year relationship. The BM filed police reports and asked the SF to leave the residence; however, the SF took the BM's keys. The SF abused marijuana daily and sold belongings to purchase marijuana. It was unknown if the SF was taking his prescribed medication for his mental health diagnosis or in treatment. The SF was verbally abusive, made threats to physically harm and had "plucked" the SC.

Determination: Indicated | **Date of Determination:** 11/15/2016

Basis for Determination:
ACS substantiated the allegations of PD/AM, LMC and IG of the SC by the SF and BM on the basis, the parents continued to use marijuana, were inconsistence with drug treatment participation, failed to ensure the SC received appropriate medical care as recommended by the ER Dr. and attend follow up medical appointments for the SC.

ACS unsubstantiated the allegations of IFCS, L/B/W, LS and M/FTTH of the SC by the SF and BM on the basis, the home was clean despite having had some insects, the home had a crib as well as adequate food and clothing for SC. The

BM had supervised interaction with the SC. The Dr. confirmed the SC was small for her age and the parents were not negligent.

OCFS Review Results:
ACS made significant effort to locate the whereabouts of the parents and SC. ACS obtained a courtesy home visit from Onondaga County to assess the safety and wellbeing of the SC.

ACS did not provide the NOE and NOI to the parents. There were incorrect response selections on the RAP. The Investigation Progress Notes reflected ACS did not obtain relevant information from contacts or cross reference the parents CPS, DV and criminal history within five days of the SCR report. Referrals for services needed by the family were not explored. The 7-Day Safety Assessment was not completed in the specified timeframe.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-Day safety assessment was not completed within the specified timeframe for the 9/16/16 SCR report.
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:
Eligibility for Preventive Services
Summary:
During the investigation, a discussion regarding the parent's eligibility for preventive services was not considered.
Legal Reference:
18 NYCRR 423.3 and 430.9
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)
09/08/2016	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Malnutrition / Failure to Thrive	Unfounded	Yes
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Lacerations / Bruises / Welts	Unfounded	
	Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Malnutrition / Failure to Thrive	Unfounded	
	Deceased Child, Female, 1	Father, Male, 29	Lack of Medical Care	Indicated	

Years	Years		
Deceased Child, Female, 1 Years	Father, Male, 29 Years	Lack of Supervision	Unfounded
Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unfounded
Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Lacerations / Bruises / Welts	Unfounded
Deceased Child, Female, 1 Years	Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unfounded
Deceased Child, Female, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Unfounded
Deceased Child, Female, 1 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Indicated
Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Lack of Medical Care	Indicated
Deceased Child, Female, 1 Years	Mother, Female, 22 Years	Lack of Supervision	Unfounded

Report Summary:
The 9/8/16 SCR report alleged, on an ongoing basis the BM and SF drank alcohol and smoked marijuana to the point of impairment as the sole caretakers of the SC. The BM and SF had parties at their home to get drunk and high while the SC was left in the back room crying for an unknown length of time. The BM and SF had turned the music up loud so they could not hear the SC. When impaired, the BM and SF had engaged in verbal and physical domestic disputes in front of the SC. The SC had no known injuries. The BM and SF had not fed the SC adequately and the SC looked younger than her actual age.

Determination: Indicated | **Date of Determination:** 11/07/2016

Basis for Determination:
The allegations of PD/AM, LMC and IG were substantiated for the SC by the parents as ACS determined the parents admitted to smoking marijuana and their non-compliance with mandated drug treatment participation. Also, the parents failed to ensure the SC received appropriate emergency medical care and they missed follow-up medical appointments for the SC. The allegations of IFCS, LBW, LS and M/FTT were unsubstantiated for the SC by the parents. ACS determined the SC was in good health, the parents provided adequate supervision of the SC and the SC was deemed small for her age by the Dr. and SC had gained weight.

OCFS Review Results:
During the review, ACS made significant efforts to locate the whereabouts of the parents and SC. ACS requested Onondaga County to conduct a courtesy unannounced home visit to assess the safety and well-being of the SC.

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

Issue:
Failure to Provide Notice of Indication

Summary:
The review revealed the NOI was not generated and provided to the parents.

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:
The review of the investigative progress note documentation revealed the NOE was not provided to the parents or generated.
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:
Appropriateness of allegation determination
Summary:
The investigative conclusion did not support the unsubstantiated allegations as selected in the investigation summary decision.
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:
Timely/Adequate Seven Day Assessment
Summary:
The 7-Day safety assessment was not accurately completed as ACS had not selected any safety factors to support the selected safety decision. The interventions ACS utilized were not fully described in the associated comments.
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 review revealed, ACS incorrectly identified the primary caregiver, made inaccurate and unsupported responses to selections on the RAP regarding the parents housing, finances, DV and mental health history.
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:
Contact/Information From Reporting/Collateral Source

Summary:
The investigative progress notes did not reflect pertinent collateral contact with the SC's medical Dr. as an allegation of the report to be investigated was LMC.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Review of CPS History
Summary:
The investigative progress notes did not reflect a cross reference of the family members CPS, DV and criminal history within five days of the SCR report. The DV protocol was not completed as the SCR narrative alleged DV and as the BM stated during ACS' interview.
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:
Failure to offer services
Summary:
The review of the investigative progress notes revealed, ACS had not discussed or offered the SF daycare services for the SC or an evaluation for the SF's mental health diagnosis.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The Investigative Determination Assessment was not accurately completed
Legal Reference:
18 NYCRR 432.2 (b)(3)(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.

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

08/26/2015	Deceased Child, Female, 1 Days	Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	Deceased Child, Female, 1 Days	Mother, Female, 21 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Female, 1 Days	Father, Male, 28 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Female, 1 Days	Mother, Female, 21 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 8/26/15 SCR report alleged the BM gave birth to the SC. The BM tested positive for marijuana in a toxicology screen. The SC had a toxicology screen and the results were pending. The roles of SF and two female surviving half-siblings; ages 5 and 7-years-old were unknown.

Determination: Indicated | **Date of Determination:** 10/23/2015

Basis for Determination:
ACS substantiated the allegations of IG and PD/AM of the SC by the BM as the BM tested positive for marijuana at the birth of the SC and admitted to using marijuana at least once during the pregnancy. The BM was enrolled in court mandated drug treatment since 9/2/15; however, she continued to test positive for marijuana. ACS unsubstantiated the allegations of ICFS of the SC by the BM and IG by the SF due to lack of credible evidence. At no time during the investigation was the SC observed by CPS without adequate provisions. The SF tested negative for substances at a random drug screen and was not observed by CPS to be under the influence during the investigation.

OCFS Review Results:
During the review, ACS made significant and relevant contacts with relatives and other collaterals. ACS assessed the SC and the family, made announced and unannounced home visits, necessary referrals (mental health evaluation, parenting and drug treatment) for the BM and diligently attempted to communicate with the foster care agency. The required safety assessments were completed within the specified timeframes. ACS was in the process of investigating the SCR report concerning allegations of IG, PD/AM of the SC by the BM on 9/22/15 when the SCR received a duplicate report. ACS continued the 8/26/15 investigation and closed the case as a duplicate report.

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

Issue:
Failure to Provide Notice of Indication
Summary:
The review revealed the NOI was not generated and provided to the BM.
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:
Timely/Adequate Seven Day Assessment
Summary:
The 7-Day and Investigative Determination safety assessments were not accurately completed. ACS had not selected a safety factor that placed the SC in immediate danger or serious harm to support the selected safety decision.
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:
Appropriateness of allegation determination
Summary:
In the investigation summary, the narrative did not support why the allegation of PD/AM was substantiated. ACS failed to provide some credible evidence of how BM's drug use placed the SC in imminent danger of serious impairment.
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 safe sleep education/information
Summary:
The review of the progress noted revealed that ACS had not documented if the parents of the then newborn SC had received safe sleep education or if it was provided by ACS.
Legal Reference:
13-OCFS-ADM-02
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 SF had no known CPS history more than three years prior to the fatality.

The BM was not named a subject of the fatality investigation. Since 2012 the two half-SS were known in three investigations; two were indicated. The allegation themes were IG, LS and PD/AM.

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 Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 09/14/2014

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?	☒	☐	☐	☐
If yes, was the response appropriate to the circumstances?	☒	☐	☐	☐

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?	☐	☐	☒	☐

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services 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.

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?	☒	☐	☐	☐

Required Action(s)

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

Foster Care Placement History

The BM was in foster care placement when ACS opened the Family Services Stage (FSS) of the case on 9/10/14. The Graham Windham agency was assigned case planning responsibility. Upon the BM aging out of foster care in 2015, she voluntarily placed the SC's two half-SS (who were then 5 and 7 years old) in foster care with a relative, due to her admitted and continued marijuana use; as well as the BM's inability to provide adequate case for the two half-SS. As of 9/8/17, the FSS remained open as the two half-SS continued kinship foster care placement with the Graham Windham agency. The two half-SS were assessed and deemed safe in the placement. The BM was not compliant with visitation and mandated service participation.

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