Child Fatality Report

Report Identification Number: NY-18-041

Prepared by: New York City Regional Office

Issue Date: Oct 15, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 04/21/2018
Initial Date OCFS Notified: 04/21/2018

Presenting Information

The 4/21/18 SCR report alleged the SC resided with the SM. The SC had been sick for the past 4-5 days, with vomiting, diarrhea, and irritability. On 4/20/18, the SC was seen by a physician and diagnosed with the flu. During the early morning hours of 4/21/18, the SM had a relative drive her and the SC to the hospital to have the SC medically evaluated. The SM held the SC on her lap and not properly secured in a car seat. The SM told her relative to drive as fast as possible and to go through a red light. The vehicle went through a red light and t-boned/hit another vehicle, causing a significant accident. EMS arrived at the scene of the accident at 2:51 AM, and found the SC not breathing and in cardiac arrest. The SC arrived at the hospital at 3:02 AM and was pronounced dead at 3:25 AM.

Executive Summary

The 6-month-old male child (SC) died on 4/21/18. The autopsy listed the cause of death as Ileocecal Intussusception and the manner of death as Natural.

At the time of the SC's death, the family had an open preventive services case with ACS supervision. On 4/21/18, the SCR registered a report that included the allegations of DOA/Fatality and IG of the SC by the SM. ACS added the allegations of IG and LS of the 12-yo, 9-yo, 7-yo and 1-yo CHN, and IG of the 17-yo CH, and LS of the SC by the SM to the report.

ACS learned that on 4/17/18, SM fed the SC in the morning and the SC vomited. On 4/18/18, the 7-yo and 9-yo half siblings (HS) had a medical appointment. The SM told the Dr. that the SC vomited when she fed him. The SM said the Dr. told her to feed the SC smaller meals more regularly, and to give the SC Pedialyte. She followed the Dr.'s instructions. On 4/19/18, during the night the SC cried, he was irritable and he did not sleep. The next day, she took the SC to Urgent Care. The nurse told her the SC had a medical condition and the SC was prescribed medication which she filled. The SM denied that the Dr. advised her to take the SC to the ER. She told the attending Dr. she would give the SC the medication, monitor him, and take him to the ER if his condition did not improve or deteriorated. Sometime after 8:00 PM, the SM's cousin invited her to come over. The SM said the SC had more energy and his health condition seemed stable. She asked the 17-yo and 12-yo HSs to care for the SC. The SM did not have a conversation with the 17-yo about supervising the SC. The SM said the 17-yo knew he was responsible for supervising the CHN whenever the SM was not in the home. The SM texted the 12-yo throughout the night. She texted him at 12:45 AM, and asked whether the SC was alright and she received no response. Initially, the SM said she returned home between 1:00 AM-2:00 AM, but then said her cousin must have dropped her off at about 2:25 AM. She went to her room to check the SC. The 12-yo and SC were asleep in her bed. She called the SC's name and observed he seemed ill. She contacted the cousin and they transported the SC in the cousin's vehicle. While in the cousin's vehicle she held the SC in her lap, and she was on the phone with the BF. She told her cousin to run the red lights; they were hit by another car. They contacted EMS, and the FDNY and EMS responded. The SC was transported to the hospital and pronounced dead. ACS placed the surviving CHN into protective custody.

On 9/10/18, ACS SUB the allegations of DOA/Fatality of the SC by the SM. The determination was based on the SM's failure to provide a minimum degree of care as the SC was diagnosed with a medical condition and provided prescriptions. The SM said the prescriptions were administered in the late afternoon. The SM received a call from her cousin and then the SM left the home. The SM admitted she left the SC in the care of the 17-yo and 12-yo HSs and did not return to the home until after 2:00 AM on 4/21/18. When she arrived home, she observed the SC seemed ill.

ACS SUB the allegations of IG and LS of the CHN. The SM was aware the SC had a medical condition and she left the

SC in the home with no adult supervision. The SM was advised by medical staff to take the SC to the ER, but the SM signed against medical advice. The SM was advised to monitor the SC to ensure his condition did not worsen. The SM admitted she went out of the home during the night of 4/20/18 leaving the SC with his siblings. At the time she left the home, there were no other adults in the home. The 17-yo was not in the home. The 12-yo said when the SM left the home, the SC was not asleep in his crib and was in the 12-yo CH's bed. The SM did not return home until 1:00 AM-2:00 AM on 4/21/18. The five surviving CHN were neglected as a derivative of the SC's neglect.

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

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:
NA

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The documentation of the RAP reflected ACS did not include accurate information concerning whether the SM had family or friends to support her in caring for the CHN.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must submit a PIP 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:	ACS documentation did not reflect that the SM's cousin was interviewed regarding the incident.
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 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: 04/21/2018 **Time of Death:** 03:25 AM

Time of fatal incident, if different than time of death: 02:00 AM

County where fatality incident occurred: Richmond
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 - but needed
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	6 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	12 Year(s)

Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	7 Year(s)
Other Household 1	Other Child - Half-sibling	No Role	Male	11 Year(s)
Other Household 1	Other Child - Half-sibling	No Role	Male	11 Year(s)

LDSS Response

LE reported the impact of the accident was insignificant. The vehicle driven by the cousin had a minor dent to the rear passenger door. Later, LE said the SM and cousin were interviewed and there were inconsistencies in their accounts. ACS did not obtain details to clarify these inconsistencies.

On 4/21/18, the SM was interviewed at the CAC. The SM said she realized the SC was ill on 4/17/18 as the SC had vomited. Per the SM's account, on 4/18/18, she took the 7-yo and 9-yo HSs to a medical appointment and at that time she spoke with the Dr. about the SC. The Dr. suggested she feed the SC small meals. On 4/20/18 the SC continued to be ill and she took the SC to Urgent Care. The physician told her the SC had a medical condition. The SC was prescribed medication. The SM said she gave the SC medication at 8:00 PM. She spoke with the 17-yo who was not home and asked him to come home. The 17-yo agreed to return home but did not do so. The SM said on the night of 4/20/18, she attended a family gathering with a cousin. She texted the CHN and continued to call them while she was out of the home. When she returned home, she observed the SC seemed strange. She and her cousin were involved in a car accident while transporting the SC to the hospital. The SC was not in a car seat. EMS transported her and the SC to the hospital.

During a subsequent interview with ACS the SM said she took the SC to Urgent Care, the nurse informed her the SC had a medical condition and the SC was prescribed medication. The SM denied that the Dr. advised her to take the SC to the ER. The SM said she told the attending Dr. that she would give the SC the medication, monitor him, and take him to the ER if his condition did not improve or worsened.

The 12-yo CH said the SM went to a party and left the SC in his care. He did not recall the time the SM left the home. He said she returned between 1:00 AM-2:00 AM. The 17-yo HS was not home when the SM left to go to the party. When the SM returned home, she woke him and told him she was taking the SC to the hospital. The 9-yo CH did not talk about the SC. The 7-yo CH did not know if anyone in the home was ill. ACS placed the CHN into protective custody. Later, the 17-yo HS said he observed the SM with the SC in front of the home and at the time he was unaware of the incident. He did not return to the home until about 2:20 AM. He said the 12-yo CH told him the SM took the SC to the hospital.

On 4/23/18, the ME said the SC did not die due to the car accident. The ME was not concerned with foul play, child abuse or neglect. A “very preliminary autopsy” revealed the SC had Intussusception. A piece of the SC’s bowel was trapped in another piece of bowel. Only with an x-ray or ultrasound would a Dr. be able to diagnose Intussusception. The ME said that having Intussusception and flu could easily “tip a child over to death.” Later, the ME confirmed the SC suffered from Intussusception.

On 4/23/18, ACS obtained information from the medical staff who had provided care of the SC during the SC’s 4/20/18 visit. The documentation showed the SC was diagnosed with a medical condition and the SM was advised that the best plan of action would be to proceed directly to the ER, as this may represent a serious or life-threatening illness. The SM refused the ER at the time and signed against medical advice (AMA).

On 4/24/18, ACS held a conference and developed a service plan that included: random drug screening for the SM, trauma Systems Therapy for the family, parenting skills (for special needs), Housing Court, bereavement counseling, compliance with medical follow-ups for the CHN, supervised visits and referral to a higher level of care.

On 4/25/18, ACS filed an Article Ten petition in the Richmond County Family Court naming the SM as the respondent. A remand of the CHN was granted. The CHN were placed in foster care with a family resource.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: 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 investigations.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047427 - Deceased Child, Male, 6 Mons	047428 - Mother, Female, 39 Year(s)	Lack of Supervision	Substantiated
047427 - Deceased Child, Male, 6 Mons	047428 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated
047427 - Deceased Child, Male, 6 Mons	047428 - Mother, Female, 39 Year(s)	DOA / Fatality	Substantiated
047429 - Sibling, Male, 17 Year(s)	047428 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated
047431 - Sibling, Male, 12 Year(s)	047428 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated
047431 - Sibling, Male, 12 Year(s)	047428 - Mother, Female, 39 Year(s)	Lack of Supervision	Substantiated
047432 - Sibling, Male, 7 Year(s)	047428 - Mother, Female, 39 Year(s)	Lack of Supervision	Substantiated
047432 - Sibling, Male, 7 Year(s)	047428 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated
047433 - Sibling, Male, 1 Year(s)	047428 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated
047433 - Sibling, Male, 1 Year(s)	047428 - Mother, Female, 39 Year(s)	Lack of Supervision	Substantiated
047434 - Sibling, Female, 9 Year(s)	047428 - Mother, Female, 39 Year(s)	Lack of Supervision	Substantiated
047434 - Sibling, Female, 9 Year(s)	047428 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated

Child Fatality Report

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate 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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☒	☐	☐	☐
If Yes, court ordered?	☐	☒	☐	☐

Explain as necessary:
On 4/20/18, ACS conducted an emergency removal of the CHN. ACS filed a pre-petition in the Richmond County Family Court on 4/23/18. A remand was granted and an OP was issued. On 4/25/18, ACS filed an Article Ten Neglect petition naming the SM as the respondent. A remand of the CHN was continued by the Family Court.

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:**
04/25/2018	There was not a fact finding	There was not a disposition
Respondent:	047428 Mother Female 39 Year(s)	
Comments:	On 4/25/18, ACS filed an Article Ten Neglect petition in the Richmond County Family Court naming the SM as the respondent.	

Have any Orders of Protection been issued? No

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? Yes
Explain:
On 5/1/18, ACS ordered beds and dressers for the CHN. A referral for bereavement services was made.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM was provided with a substance abuse test on 5/14/18. She tested negative for all substances. A referral for bereavement services was made.

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

Child Fatality Report

Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? Yes

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)	Allegation Outcome	Compliance Issue(s)
05/30/2017	Sibling, Male, 6 Years	Mother, Female, 38 Years	Lack of Medical Care	Substantiated	Yes
	Sibling, Male, 6 Years	Mother, Female, 38 Years	Excessive Corporal Punishment	Substantiated	
	Sibling, Male, 6 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 6 Years	Mother, Female, 38 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 16 Years	Mother, Female, 38 Years	Excessive Corporal Punishment	Substantiated	
	Sibling, Male, 16 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 16 Years	Mother, Female, 38 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 8 Years	Mother, Female, 38 Years	Excessive Corporal Punishment	Substantiated	
	Sibling, Female, 8 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 8 Years	Mother, Female, 38 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 12 Years	Mother, Female, 38 Years	Excessive Corporal Punishment	Substantiated	
	Sibling, Male, 12 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	

	Sibling, Male, 12 Years	Mother, Female, 38 Years	Lack of Supervision	Substantiated

Report Summary:
The 5/30/17 SCR report alleged that on an unknown date within the past week, the 6-yo CH sustained first and second degree burns to the left side of his neck, left forearm, and upper arm that were blistering in some areas. The SM had not sought the medical treatment needed for the CH's burns.

Report Determination: Indicated | **Date of Determination:** 07/26/2017

Basis for Determination:
The CH sustained burns about his body and face, and the SM did not seek medical care. ACS added the allegations of IG, XLMC of the 16-yo, 12-yo, and 8-yo CHN to the report. These allegations were added for the 6-yo CH. The SM did not provide an explanation for the degree of the marks and burns the 6-yo sustained. The CHN sustained marks about their body that was determined by a medical professional to be consistent with a pattern that seemed like a belt mark. The SM was unable to articulate the CHN's whereabouts on multiple occasions and also how the 6-yo CH sustained burn marks.

OCFS Review Results:
The SM was in her home when the incident regarding the 6-yo's neck and arm occurred. The SM saw the marks after the CH played with the 8-yo. The SM used over-the counter medication on the burn-like marks and did not think the CH required medical attention. The 6-yo CH said he fell on his face while playing outside with the 8-yo CH. He said the SM hit him with a belt. He said "multiple" statements to ACS on how he sustained the marks. He had burn-like marks on his face and left forearm. He had linear marks on his arm and back. On 5/31/17, a forensic interview at CAC occurred. The 6-yo said he and the 8-yo get hit by a belt. On 6/6/17, ACS filed an Article Ten petition in Family Court.

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

Issue:
Adequacy of Progress Notes
Summary:
ACS documentation reflected there were progress note entries that were repeated/copied, including an event that occurred on 6/20/17 and the note was repeated and copied in the progress notes.
Legal Reference:
18 NYCRR 428.5
Action:
ACS must submit a PIP 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 Seven Day Assessment
Summary:
The 7-day safety assessment was inadequate. An associated comment did not support the selected safety factor that stated the CHN experienced serious and/or repeated physical harm or injury and/or the parent made a plausible threat of serious harm or injury to the CHN.
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 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:
Pre-Determination/Assessment of Current Safety/Risk
Summary:

The Investigation Determination safety assessment was inadequate. An associated comment did not support the selected safety factor that stated the CHN experienced serious and/or repeated physical harm or injury and/or the parent made a plausible threat of serious harm or injury to the CHN.

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 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 Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/30/2016	Sibling, Male, 11 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 11 Years	Mother, Female, 37 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

The 9/30/16 SCR report alleged that the SM had not brought the 11-yo CH to the dentist since August 2016 although she was aware he had a tooth ache and was in pain.

Report Determination: Unfounded **Date of Determination:** 11/29/2016

Basis for Determination:

ACS found that prior to the 9/30/16 report, the SM contacted the school staff and informed them that she was in the process of moving to a shelter and once established she would take the CH to the dentist. Once the family relocated to the shelter, the SM went to two dental offices and attempted to have the CH treated by a dentist. The SM's attempts were unsuccessful because she did not have the CH's physical insurance card so the CH could only be seen at the hospital for emergency, but having a cavity was not sufficient. The SM had misplaced the CH's insurance card due to relocating. The SM had since contacted the insurance company and requested the replacement cards.

OCFS Review Results:

ACS interviewed the SM, CHN, and Safe Space CP regarding the case circumstances. The SM said the 11-yo CH received dental examinations. The SM received a call from the school staff who said the 11-yo complained of a toothache. The SM explained that prior to the time the child left home for school, he had not complained. He had left the school complaining of a tooth ache, but after 10 minutes of being home he requested to go outside and play. The SM told the school staff she was going to make an appointment but it was difficult as she was packing and preparing to move into a shelter. The 11-yo said his tooth only hurt when he ate. The SM received services from the Safe Space agency.

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

ACS documentation did not reflect that diligent efforts were made to interview the family's social worker at the shelter. ACS did not interview the service provider who had been providing therapeutic services to the 11-yo and 7-yo CHN.

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 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 Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/20/2016	Sibling, Male, 15 Years	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 15 Years	Mother, Female, 37 Years	Lack of Medical Care	Substantiated	

Report Summary:
The 5/20/16 SCR report alleged that the 15-yo was prescribed medication and the SM did not ensure he obtained his medication. As a result, the 15-yo was deteriorating. The CH made threats to harm others. These concerns occurred throughout the year. The SM was aware of the negative effect of the 15-yo not receiving his medication, but she failed to take any action to rectify the situation. The SM prolonged much needed medical care for the 15-yo CH.

Report Determination: Indicated **Date of Determination:** 06/30/2016

Basis for Determination:
The SM failed to meet the need of the 15-yo and 11-yo CHN by not ensuring they received their medications as prescribed. The CHN had not been consistent in taking their medication and there had been a prolonged period of time where the CHN did not see the clinical Dr. As a result there had been no medication prescribed during that time. The SM's action was inappropriate as she did not ensure the CHN's needs were met.

OCFS Review Results:
ACS findings showed that the SM had not been providing the school with the correct information concerning which physician prescribed the 15-yo CH's medication. Following the ACS intervention, the school staff and the SM resolved the issue concerning the prescription. The SM had a meeting at the school about the CH's medication. Then the CH saw the physician who had prescribed the required medication. The SM was provided with documentation for the prescribing Dr. to complete and return.

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

Issue:
Pre-Determination/Supervisor Review

Summary:
The CPS Investigation Summary of the determination was inadequate as the Investigation Conclusion Narrative reflected that the SM failed to meet the needs of the 15-yo and 11-yo; however, in the allegation information section ACS did not include the allegations of IG and LMC of the 11-yo CH by the SM.

Legal Reference:
18 NYCRR 432.2(b)(3)(v)

Action:
ACS must submit a PIP 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.

[redacted]

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

The SM was known to the SCR and ACS as a subject in two reports dated: 6/6/12 and 2/2/15. The SM was listed as having no role in two cases dated: 11/3/10 and 6/10/13.

The allegations of the 6/6/12 investigation were IG and L/B/W. On 8/3/12, ACS UNF the report. The allegations of the 2/2/15 investigation was IG and LS. The report was IND.

The 17-yo, 7-yo, 12-yo, and 9-yo were known as confirmed maltreated CHN in a report dated 6/10/13. The allegation of

the report was IG. The 17-yo CH was also known as a non-confirmed maltreated CH in a report registered on 11/3/10. The allegations of the report were XCP, IG and L/B/W.

Known CPS History Outside of NYS

There was no known 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: 03/25/2015

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: 03/25/2015

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?	☒	☐	☐	☐
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: During the 2/2/15 investigation, a preventive case was opened on 3/25/15; ACS referred the family for FPP.The 10/21/17				

FASP reflected the family signed an application for services with the Jewish Board of Family and Children's Services as of 12/20/16. On 6/6/17, ACS filed an Article Ten petition in Family Court. The SM accepted an ACD.

Required Action(s)

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The 4/21/18 FASP safety assessment reflected the selected safety decision was no safety factors identified; however, there was a limited OP in effect in which the SM maintained custody of the CHN, but was not permitted to employ corporal punishment.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency 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:	Adequacy of case planning
Summary:	During the ACS visit on 4/19/18, two days prior to the fatality, the SM informed ACS that the SC had a stomach virus, but ACS did not ask about the SC's condition and did include monitoring of the SC's medical needs in the service plan.
Legal Reference:	18 NYCRR 432.2 (b)(2)
Action:	ACS must submit a PIP 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:	Adequacy of Child Protective Services casework contacts
Summary:	ACS documentation reflected that during the home visits conducted between 1/8/18 and 4/19/18, ACS did not interview the children who were of interviewing age even though they were available at the time of the home visits.
Legal Reference:	432.2(b)(4)(vi)
Action:	ACS must submit a PIP 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:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The 10/21/16 FASP completed by Sheltering Arms/Safe Space was inadequate. The RAP reflected the agency did not include the family's history of unstable housing. The FASP reflected the family relocated to a shelter.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must submit a PIP 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:	The documentation of the Jewish Board of Family and Children's Services agency reflected that the notes were not entered contemporaneously, including an event that occurred on 4/28/17, but was not entered until 5/30/17.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP 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 safe sleep education/information
Summary:	The Jewish Board of Family and Children's Services progress notes reflected that the agency did not provide the SM with safe sleep information when the SC was born.
Legal Reference:	13-OCFS-ADM-02
Action:	ACS must submit a PIP 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 Offer Services
Summary:	During court ordered supervision, ACS did not offer the SM homemaking services to assist her with care of six CHN: age range from an infant to a 17-yo.
Legal Reference:	SSL 424(10); NYCRR 428.6
Action:	ACS must submit a PIP 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

On 1/8/07, an Advocates Preventive Only (ADVPO) intake case was opened as the 17-yo CH had behavioral needs. The intake case was closed on 1/17/07. An ADVPO case was opened on 2/13/07 and pertained to the 17-yo CH because the family requested individual counseling. The case was closed on 4/10/07.

During the 2/2/15 investigation, a preventive services case was opened on 3/25/15 as there was a need for Family Preservation Program (FPP) services. The FASP of 4/24/15 reflected the family was scheduled to receive case management services. ACS referred the family for PPRS. The SM signed an application for services with Sheltering Arms/Safe Space (SA/SS) agency on 6/15/15. The 10/21/17 FASP reflected the family signed an application for services with the Jewish Board of Family and Children Services agency as of 12/20/16 and was in the Stabilization phase of treatment. The family was investigated by ACS in May 2017, and it was determined that the CHN had marks on their backs consistent with belt marks. On 6/6/17, ACS filed an Article Ten petition in the Richmond County Family Court. A limited OP was put in place stipulating that the SM maintain custody of the CHN, but would not employ corporal punishment against them. In February 2018, the SM accepted an ACD.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
06/06/2017	Adjudicated Neglected	Adjourned in Contemplation of Dismissal (ACD)
Respondent:	047428 Mother Female 39 Year(s)	
Comments:	On 6/6/17, ACS filed an Article Ten Neglect petition naming the SM as the respondent. A limited OP was put in place stating that the SM would maintain custody of the CHN, but would not employ corporal punishment against them. ACS documentation reflected that in February 2018, the SM accepted an ACD that expired on 6/29/18. The terms included compliance with PPRS, make efforts to ensure the CHN attend school and compliance with a limited OP for the CHN refraining from using any corporal punishment. The five CHN were under ACS supervision.	

Have any Orders of Protection been issued? Yes	
From: 06/06/2017	**To:** 06/29/2018
Explain: A limited OP was issued on 6/6/17 for the SM regarding the CHN. The limited OP was continually renewed at each Family Court hearing with a final expiration date of 6/29/18.	

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