Child Fatality Report

Report Identification Number: NY-16-128

Prepared by: New York City Regional Office

Issue Date: Jun 30, 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	

Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 8 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 11/30/2016
Initial Date OCFS Notified: 11/30/2016

Presenting Information

The OCFS Form 7065 noted the infant was born extremely premature at 25 weeks gestation at Bellevue Hospital in March 2016. The infant was born with cardiac, respiratory, gastrointestinal issues and he had bleeding on the brain. The BM contacted ACS and indicated the infant died at Bellevue Hospital on 11/30/16.

Executive Summary

This 8-month-old medically fragile infant died on 11/30/16. The infant was pronounced dead by the Bellevue Hospital attending physician. The infant's death was not referred to the ME for an autopsy. In May 2017, ACS informed NYCRO that the medial staff suggested the infant's death was due to prematurity (25 weeks gestation) and multiple medical needs.

The family had an open Child Protective case for Court Ordered Services with ACS supervision. The case was open to address the parents' drug misuse and drug sales in the home in the presence of the children. Following the infant's birth, he remained hospitalized until the time of his death. During the period of hospitalization, the parents visited the infant and participated in planning activities. ACS staff visited the infant in the hospital, assessed his treatment plan and provided support to the family. During an interview with ACS on 11/7/16, an assigned nurse indicated that the hospital was in the process of transitioning the infant to a rehabilitation facility for long term medical care. There was no anticipated date of neonatal intensive care unit discharge. Following the infant's death, the hospital staff said the infant's death was unexpected.

ACS submitted to NYCRO the completed OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive cases. The information regarding the infant's death was reported to OCFS under Chapter 485 of the Laws of 2006. ACS included the information in the open Child Protective case for further exploration.

According to the completed OCFS 7065 document, the BM did not receive prenatal care and she hid her pregnancy from ACS. The infant was born extremely premature at 25 weeks gestation. At the time of the infant's birth, the BM tested positive for marijuana and the infant tested negative. The infant was admitted for treatment of cardiac, respiratory, gastrointestinal, and bleeding on the brain medical condition. The medical staff could not confirm whether there was a correlation between the infant's prematurity, the lack of pre-natal care and the BM's use of marijuana.

Following the infant's death, ACS staff contacted the BM by telephone on 11/30/16, discussed the infant's death and attempted to schedule a home visit. The BM did not agree to the visit and she said she believed ACS was being insensitive. The staff observed and engaged two siblings and a female half sibling in school on 12/1/16. There were no safety concerns regarding these three children. ACS case record did not include information to verify that the other three surviving children were observed for safety assessment within seven days of notification of the infant's death. Eventually, ACS observed the BM and her six surviving children at the case address on 12/21/16. The home was clean, the family had an adequate supply of food and the children did not have visible marks or bruises.

ACS noted the BM was compliant with the service plan requirements. The service plan included: random drug screening, psychotherapy services for the BM; bereavement counseling and exploring homemaking for the family; educational monitoring and play therapy for age appropriate children, and case management. ACS continued to visit the home and monitor the BM's random drug screening results. The ACS case record did not include the test results from 3/2/17 through 5/22/17. There was no detail about the suggested play therapy for the age appropriate children. NYCRO received information from ACS staff who stated the stepfather continued to assist the BM with obtaining permanent housing but the whereabouts of the BF (infant's father) were unknown.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
N/A

Was the decision to close the case appropriate? N/A

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

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

Explain:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	The ACS case record did not reflect whether ACS attempted to observe the two older half siblings in school to conduct the safety assessment within seven days of notification of the infant's death.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/30/2016 **Time of Death:** 02:12 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
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: Hospital

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
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	No Role	Male	8 Month(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Stepfather	No Role	Male	43 Year(s)
Other Household 1	Father	No Role	Male	32 Year(s)
Other Household 1	Sibling	No Role	Male	11 Year(s)

LDSS Response

The family resided in a scatter site shelter supervised by the New York City Department of Homeless Services. ACS

attempted to visit the home on 12/1/16. The effort was unsuccessful because the ACS Specialist was unable to gain entry to the case address building. The Specialist established telephone contact, offered condolence to the BM and discussed arrangement for a home visit. The BM did not agree to the visit, she expressed anger and ended the conversation. ACS made plans to visit the children in school.

During a school visit on 12/1/16, the 8-year-old female half-sibling expressed feelings of sadness. The Specialist appropriately addressed the half-siblings remarks. The Specialist asked her about the BM and she said the BM played music and cried. The Specialist observed this half sibling and the 6-year-old and 4-year-old siblings wore appropriate clothing and they were actively engaged in school. The ACS case record did not reflect whether the Specialist attempted to visit the two other school-age half-siblings' school, or observe these half siblings prior to 12/21/16.

The attending Dr. provided information that reflected the infant had several pre-existing medical issues. The infant had been breathing on his own but required oxygen to assist with breathing. The infant's cause of death was deemed unknown pending additional studies. The death was not referred to the ME as the Bellevue Hospital medical staff planned to conduct a microscopic autopsy. The social worker recalled the BM consistently visited and participated in planning for the infant, and the BF visited less frequently than the BM. The hospital provided bereavement counseling/intervention to the family.

ACS notified the Family Court Legal Services (FCLS) attorney of the infant's death. The ACS case record did not indicate whether FCLS provided any new directives. The Family Services Unit team held a Child Safety Conference (CSC) on 12/1/16 and discussed plans to support the family. According to the ACS case record, the BM was not at the meeting because ACS attempts to contact her were unsuccessful. The CSC participants agreed to continue the Court Order Supervision with no petition for additional legal intervention. ACS decided to provide bereavement support and play therapy as needed, monitor random drug testing, and continue attempts to contact and involve the infant's BF and stepfather in the service plan.

The BM received therapeutic services from a Community Based Organization (CBO). ACS contacted the CBO and requested updated documentation pertaining to an evaluation of the BM's "insight and judgment" on 12/2/16. The ACS case record did not state whether ACS obtained the documentation as requested. Subsequently, NYCRO contacted ACS and requested updated information about the case circumstances. ACS provided written documentation that reflected the King's County Family Court hearing discussed reports from the mother's therapist. ACS noted the BF's whereabouts were unknown.

ACS received the funeral home invoice from the BM and assisted the family with obtaining financial support for burial on 12/9/16. Between 12/21/16 and 4/26/17, ACS staff made the required number of casework contacts to meet the program requirement. The ACS Specialist interviewed and observed the BM and children in the home and engaged the children in their respective schools. The children had no visible marks or bruises and the home condition was adequate. The Specialist addressed housing and employment concerns with the BM. The BM expressed concern as she had not received an autopsy report for the infant. ACS received the BM's drug screening results and noted they were negative for all illicit substances.

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: Hospital physician

Multidisciplinary Investigation/Review

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.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
There was no LE involvement. The case was not referred to the ME for an autopsy. ACS did not enter several Family Services Progress Notes within the required 30-day timeframe.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☐	☒	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate	☒	☐	☐	☐

danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?				
Explain: ACS did not observe the surviving children within 7 days of notification of the fatality. The efforts to visit the home were unsuccessful because the BM did not allow ACS entry to the home. ACS did not make additional efforts to observe the two older half siblings in school.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: N/A				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
As of 5/26/17, the case remains open for COS.

The 2-year-old sibling received an Early Intervention evaluation and was found to be developing well. He was referred for follow-up evaluation in June 2016.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The surviving children received bereavement, family support, and case management services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The BM received drug counseling/treatment, bereavement services and case management services. The BF and stepfather did not make themselves available for services.

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

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/02/2016	16421 - Deceased Child, Male, 9 Days	16422 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	Yes
	16431 - Sibling, Male, 3 Years	16422 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	16442 - Other - Half-sibling, Female, 13 Years	16422 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	16424 - Sibling, Male, 1 Years	16422 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	16432 - Sibling, Female, 5 Years	16422 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	16433 - Other - Half-sibling, Female, 7 Years	16422 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	16441 - Other - Half-sibling, Male, 10 Years	16422 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 4/2/16 SCR report alleged on a regular basis the BM sold marijuana out of the home in the presence of the infant's two half-siblings and three siblings. The report also alleged there was a lot of drug traffic in and out of the home while

the children were present. The BM also left drugs and drug paraphernalia accessible to the children. The MGF had an unknown role.

The 4/4/16 SCR report alleged the BM had been dealing drugs in the presence of all her children with the exception of the infant who was still hospitalized. The report also alleged on 4/2/16, the BM was arrested in the presence of the children for dealing drugs. The children were not physically harmed.

Determination: Indicated | **Date of Determination:** 06/07/2016

Basis for Determination:
ACS substantiated the allegation of IG of the BM's seven children by the BM on the basis that there was a drug raid in the home on 4/2/16 which revealed the BM had 20 bags of marijuana, two scales with residue, and loose marijuana out in the open on the bed accessible to the children. The BM sold drugs in the home in the presence of the children. The BM was arrested and released pending her criminal case.

OCFS Review Results:
ACS attempted to visit the family within 24 hours of receipt of the 4/2/16 report. The efforts were unsuccessful until 4/4/16 when ACS staff interviewed and/or engaged the BM and six children in the home. The infant, who was born in March 2016, had remained in the hospital. The BM denied she had drugs or drug paraphernalia in the home. ACS verified LE arrested and charged the BM. ACS filed an Article Ten Neglect petition in Family Court on 4/6/16. The six older children were remanded to the Commissioner of ACS and placed in foster care. For the 4/2/16 and 4/4/16 reports, ACS did not provide the determination notices to the BM and PGF, who were the subject and "other person," respectively.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
ACS identified family members as the children's caregivers and persons legally responsible. However, in the RAP, ACS did not assign a Secondary Caretaker to the case.

Legal Reference:
18 NYCRR 432.2(d)

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

Issue:
Failure to Provide Notice of Indication

Summary:
ACS did not provide the required Notice of Indication to the BM and PGF who were listed in the 4/2/16 and 4/4/16 reports as the subject and "other person," respectively.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

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

Issue:
Adequacy of case recording

Summary:

During the investigation of the 4/4/16 report, the Investigation Progress Notes did not include adequate information about the stepfather and infant BF's relationship with the children, their ability and willingness to supervise the children, and status of involvement in service planning.

Legal Reference:

18 NYCRR 428.5(c)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/16/2014	16601 - Sibling, Male, 2 Months	16591 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated	Yes
	16623 - Other - Half-sibling, Male, 8 Years	16591 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated	
	16624 - Other - Half-sibling, Female, 9 Years	16591 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated	
	16621 - Sibling, Male, 1 Years	16591 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated	
	16622 - Sibling, Female, 3 Years	16591 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated	
	16601 - Sibling, Male, 2 Months	16592 - Father, Male, 29 Years	Inadequate Guardianship	Indicated	
	16621 - Sibling, Male, 1 Years	16592 - Father, Male, 29 Years	Inadequate Guardianship	Indicated	
	16622 - Sibling, Female, 3 Years	16592 - Father, Male, 29 Years	Inadequate Guardianship	Indicated	
	16623 - Other - Half-sibling, Male, 8 Years	16592 - Father, Male, 29 Years	Inadequate Guardianship	Indicated	
	16624 - Other - Half-sibling, Female, 9 Years	16592 - Father, Male, 29 Years	Inadequate Guardianship	Indicated	

Report Summary:

The 8/16/14 SCR report alleged on 8/16/14 a search warrant was executed on the family's home because of a suspicion of drug sales. The search uncovered a moderate amount of marijuana which was packaged for sale. The BF sold marijuana from within the family's home while the five children were present. The BM was aware of the BF drug dealings and she took no actions to protect her children from this illegal activity. The parents were arrested for possession of marijuana and for illegal sales of marijuana. The family's home was unsanitary. No specific details were given. The PGM's role in regards to this report was unknown.

Determination: Indicated | **Date of Determination:** 09/26/2014

Basis for Determination:

ACS substantiated the allegation of IG of the five children by the BF and BM on the basis of findings that showed the BM had knowledge of BF "dealing/selling drugs, which was illegal, and exposing the children to the drugs." ACS noted the BM and BF were arrested for sale and possession of marijuana.

OCFS Review Results:

ACS verified five children were with the BM and BF in the PGM's home at the time LE found marijuana in the PGM's home. The oldest half sibling was in the MGM's home. The BM did not have a permanent home and ACS initially observed two children in the PGM's home and four children in the MGM's home. The BM was charged with possession and the BF with sale and possession of marijuana. During the interview with ACS, the BF denied he sold marijuana but he admitted he smoked marijuana. The BM denied she used, sold or had marijuana in the home. ACS provided safe sleep practices education to the BM. ACS did not provide the Notice of Indication to the BM, BF and PGM who were listed in the report.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 8/22/14 safety assessment did not identify the safety factor that placed the children in immediate danger of serious harm. ACS did not develop a safety plan for the family although the agency implemented judicial intervention.

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

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

Issue:
Predetermination/Assessment of Current Safety and Risk

Summary:
In the 9/26/14 Investigation Determination safety assessment, ACS did not identify the safety factor that actually placed the children in immediate danger of harm. ACS did not outline a safety plan for the family although the agency implemented judicial intervention.

Legal Reference:
18 NYCRR 432.1(aa)

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

Issue:
Failure to Provide Notice of Indication

Summary:
The ACS case record did not reflect the BM, BF, and PGM, who were the subjects and "other person," respectively were provided the required Notice of Indication for the 8/16/14 report.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

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

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

06/10/2014	16634 - Sibling, Male, 2 Days	16631 - Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Indicated	Yes

Report Summary:
The 6/10/14 report alleged the newborn infant tested positive for marijuana at the time of delivery. The report also alleged the BM refused a drug test.

Determination: Indicated **Date of Determination:** 08/08/2014

Basis for Determination:
ACS substantiated the allegation of PD/AM of the sibling, who was then a newborn infant, on the basis of infant "born with a positive toxicology."

OCFS Review Results:
The MGM assisted the BM with care of the children. There was no detail of BF involvement. The BM had a diagnosed condition for which an attending Dr. referred her to outpatient chemical dependency program. The Dr. said the BM did not present a danger to herself and/or others. In the Investigation Conclusion Narrative, ACS did not assess the impact of the BM's drug use on the care she provided the newborn infant. The safety assessments did not identify the safety factor that placed the children in immediate danger, nor include safety plans. ACS did not assign a Secondary Caretaker in the RAP. Events dated 6/11/14 were not entered until 8/08/14.

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

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

Summary:
ACS substantiated the allegation of PD/AM of the child, who was then a newborn infant, by the BM. However, in the Investigation Conclusion Narrative, ACS did not provide justification regarding the impact of the BM's drug use on the care the child received. ACS did not appropriately apply the legal standards of abuse/maltreatment to the case circumstances.

Legal Reference:
SSL 412(1) and 412(2)

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
ACS inappropriately completed the Investigation Determination safety assessment dated 8/6/14. In the safety assessment document, ACS did not identify the safety factors that placed the children in immediate danger, and the agency did not include a safety plan to incorporate the caretakers' responsibilities and monitoring activities to protect the children.

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

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:

ACS completed a RAP dated 8/8/14. However, the ACS did not assign a Secondary Caretaker although the MGM and step father and infant's BF assisted with supervision and support of the children.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

ACS did not enter some Investigation Progress Notes within the required 30-day timeframe. CONNECTIONS reflects there were events that occurred on 6/11/14 that were not entered until 8/8/14.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

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

Issue:

Failure to Provide Notice of Indication

Summary:

The ACS case record did not reflect ACS provided the Notice of Indication to the BM who was the subject in the 6/10/14 report.

Legal Reference:

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

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/30/2014	16871 - Sibling, Male, 1 Years	16861 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated	Yes
	16873 - Other - Half-sibling, Female, 5 Years	16861 - Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated	
	16872 - Sibling, Female, 2 Years	16866 - Stepfather, Male, 40 Years	Inadequate Food / Clothing / Shelter	Indicated	
	16874 - Other - Half-sibling, Male, 10 Years	16866 - Stepfather, Male, 40 Years	Inadequate Food / Clothing / Shelter	Indicated	
	16872 - Sibling, Female, 2 Years	16861 - Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated	
	16874 - Other - Half-sibling, Male, 10 Years	16861 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated	

16873 - Other - Half-sibling, Female, 5 Years	16866 - Stepfather, Male, 40 Years	Inadequate Food / Clothing / Shelter	Indicated
16875 - Other - Half-sibling, Female, 11 Years	16866 - Stepfather, Male, 40 Years	Inadequate Guardianship	Indicated
16875 - Other - Half-sibling, Female, 11 Years	16861 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated
16872 - Sibling, Female, 2 Years	16866 - Stepfather, Male, 40 Years	Inadequate Guardianship	Indicated
16871 - Sibling, Male, 1 Years	16861 - Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated
16872 - Sibling, Female, 2 Years	16861 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated
16875 - Other - Half-sibling, Female, 11 Years	16861 - Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated
16873 - Other - Half-sibling, Female, 5 Years	16866 - Stepfather, Male, 40 Years	Inadequate Guardianship	Indicated
16873 - Other - Half-sibling, Female, 5 Years	16861 - Mother, Female, 28 Years	Inadequate Guardianship	Indicated
16871 - Sibling, Male, 1 Years	16866 - Stepfather, Male, 40 Years	Inadequate Food / Clothing / Shelter	Indicated
16874 - Other - Half-sibling, Male, 10 Years	16866 - Stepfather, Male, 40 Years	Inadequate Guardianship	Indicated
16874 - Other - Half-sibling, Male, 10 Years	16861 - Mother, Female, 28 Years	Inadequate Food / Clothing / Shelter	Indicated
16871 - Sibling, Male, 1 Years	16866 - Stepfather, Male, 40 Years	Inadequate Guardianship	Indicated
16875 - Other - Half-sibling, Female, 11 Years	16866 - Stepfather, Male, 40 Years	Inadequate Food / Clothing / Shelter	Indicated

Report Summary:
The 1/30/14 SCR report alleged the BM, stepfather and five children lived in a deplorable home. The report also alleged the home was roach infested. The floor was covered with dirt and the sibling, who was then 2 years old, squatted down and licked sugar off the floor at some point during the week prior to 1/30/14. There was no heat in the home. The BM used the gas stove to heat the house. The children's hygiene was very poor. The condition of the home was unsanitary and a health hazard to the children.

Determination: Indicated | **Date of Determination:** 03/31/2014

Basis for Determination:
ACS substantiated the allegations of IF/CS and IG of the five children by the BM and stepfather on the basis that the family made minimal effort to get heat and electricity in the home. ACS staff had observed the family home did not have electricity and heat. ACS "observed the family using the stove to heat the apartment and also an extension cord extending from outside of the apartment."

OCFS Review Results:
Between 1/30/14 and 2/3/14 ACS attempted to contact the family. The efforts were unsuccessful as the family was not at home. ACS staff observed and interviewed two half-siblings in school on 2/4/14. These half-siblings said the family resided with relatives for a few days. ACS staff observed and engaged all household members at the case address on 2/10/14. ACS staff observed an extension cord extending from the hallway into the apartment. The BF acknowledged he connected the cord for the utilities. Following ACS intervention, the family resided with the MGM as part of the safety

plan. The BM obtained housing entitlement to locate to another apartment.

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

Issue:
Failure to Provide Notice of Indication
Summary:
ACS did not provide a Notice of Indication to the BM and stepfather who were the subjects of the 1/30/14 report.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Adequacy of Documentation of Safety Assessments
Summary:
In the 3/31/14 Investigation Determination safety assessment ACS selected the safety factor that stated the children's whereabouts could not be ascertained. The selected safety factor was inaccurate because the 3/26/14 Investigation Progress Note stated ACS staff observed the five children on 3/26/14, and the 3/31/14 managerial review showed the family resided in the MGM's home.
Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:
ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

The family was known in three reports dated 3/27/10, 11/2/11 and 12/6/11. The allegation of the 3/27/10 report was IG of a female half-sibling, who was then 11 years old, by the BM, stepfather, and MGF. On 5/27/10, ACS substantiated the allegation of the 3/27/10 report after the agency found the half-sibling was sexually molested. The half-sibling did not disclose the identity of the individual who molested her. ACS noted the parents were "responsible for not providing the child the proper guardianship and safety to prevent this."

The allegations of the 11/2/11 report were IG and PD/AM of the female half-sibling, who was then two years, old and the female sibling by the BM and the BF. On 12/16/11, ACS substantiated the allegations of the 11/2/11 report on the basis that LE arrested the subject parents as they found marijuana and drug paraphernalia in the home.

The allegation of the 12/6/11 report was IG of the male half sibling, who was then six years old, by the stepfather. On 2/6/12, ACS unsubstantiated the allegation of the 12/6/11 report on the basis of lack of credible evidence to support a finding of abuse/maltreatment.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 02/26/2014

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 02/26/2014

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

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The FASP due 10/27/16 was completed on 11/5/16.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐
Additional information, if necessary:				

The family received services with ACS. The BM refused PPRS.

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	A Reassessment FASP was due on 10/27/16. ACS completed the FASP on 11/5/16. The FASP due in April 2017 was not generated.
Legal Reference:	18 NYCRR428.3(f)
Action:	ACS must submit a performance improvement plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Preventive Services History

Between 4/8/10 and 11/12/13, the family received Court Ordered Services (COS) to address DV, sexual abuse, parents' marijuana misuse and sales in the home, hazardous living condition, and the BM's failure to make herself available for contact. ACS closed the case after finding the children received adequate care and supervision, they attended school regularly, and the Dr. noted there were no concerns with their development. The family received housing entitlement and the BF completed parenting skills on 9/20/13.

ACS opened the Family Services Stage on 2/26/14 and provided the family with Family Preservation Program(FPP) intervention from 3/3/14 through 4/23/14. ACS terminated FPP as the BM did not make herself available for FPP support. ACS filed an Article Ten Neglect petition in the Kings County Family Court and the judge released the children to the BM with COS on 6/16/14. The BM received therapy and random drug screenings, and the age appropriate siblings received Early Intervention evaluations. The BM tested negative for illicit substances but she did not always report to the testing site. She was resistant to services, refused ACS access to some of the home visits, and refused PPRS.

ACS did not enter the Family Services Progress Notes contemporaneously. Events that occurred 1/12/16 and 4/18/16 were entered on 4/12/16 and 11/30/16, respectively.

Required Action(s)

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

Foster Care Placement History

ACS filed an Article Ten Neglect petition filed in the Kings County Family Court in April 2016 and the judge remanded six of the children (the infant's three half-siblings and three siblings) to the care and custody of the Commissioner of ACS.

The infant had remained in Bellevue Hospital for treatment of his pre-existing medical conditions. The infant's three half-siblings were placed in the kinship home of their PA, and the three siblings were placed in the home of their PGM on 4/25/16. These two kinship homes were located in Brooklyn. The Edwin Gould Children and Family Services agency was assigned case planning responsibility. The agency completed the required number of casework contacts to meet the program requirement.

The six children were discharged from kinship foster care and retuned to the BM's care on 7/11/16. The family relocated from Brooklyn because the BM and children were taken to the Prevention Assistance Temporary Housing and placed in a shelter in the Bronx on 7/11/16. The foster care services ended and the family received COS with ACS supervision.

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:**
04/06/2016	Adjudicated Neglected	Order of Supervision
Respondent:	037702 Mother Female 30 Year(s)	
Comments:	On 4/12/17, the judge ordered the six surviving children released to the BM with court ordered ACS supervision for three months to expire on 7/12/17. ACS was ordered to make bi-weekly home visits unannounced and announced. The BM must comply with the following: submit	

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