Child Fatality Report

Report Identification Number: NY-21-108

Prepared by: New York City Regional Office

Issue Date: Mar 30, 2022

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 10/06/2021
Initial Date OCFS Notified: 10/06/2021

Presenting Information

The 10/6/21 SCR report alleged that on 10/6/21, the SM and SF were giving the SC a bath. The SM and SF left the SC unsupervised for an unknown amount of time. When the SM returned, the SC was unresponsive under water in the bathtub. The SM took the SC out of the bathtub and placed him on the floor. The SF entered the room and began CPR on the SC. The SM ran out into the hallway of the shelter where EMS technicians were already on scene for another matter. EMS called for additional units at 3:34 PM. They entered the room and the SC was on the floor about five feet from the bathroom, he was unresponsive and had no pulse. EMS took over CPR and transported the SC to the hospital. The SC was pronounced dead at 4:30 PM.

Executive Summary

The 1-year-old male subject child (SC) died on 10/6/21. As of 3/9/22, NYCRO had not received a copy of the ME's report.

At the time of the incident, the SC resided in a shelter with the SF, SM, the 3-yo and 4-month-old SSs. The SF was the father to the 4-month-old SS. The SF had three additional children from two prior relationships: a 10-yo male CH and 3-year-old female twins residing with their respective mothers.

ACS learned that the SM left the home to pick up the 3-yo child from school and when she arrived home, she saw feces on the bedding from the SC's diaper. The SM removed the diaper and put the SC in the bathtub. The SM told the 3-yo SS to go in the bathroom and play with the SC and keep him company. At about 3:15PM, she heard the 3-yo and SC screaming and playing while she cleaned the bed. The SM completed a few tasks then entered the bathroom and found the SC under water in the tub facing up. The SM picked up the SC who opened his eyes and then closed them. The SM screamed for help. The SF began CPR on the SC. The SM called 911 and while on the phone she saw an ambulance downstairs and ran to the technicians to ask for help. The technicians entered her home and took over CPR from the SF. The SC was transported to the hospital and pronounced dead.

On 10/7/21, ACS opened a service case and filed a pre-petition. The court granted a remand of the two SSs who resided in the home with a direct placement to the MGM contingent upon a home assessment. The judge ordered liberal visits with a resource who had been approved by ACS. No overnight visits could occur in the MGM's home. The pre-petition was dismissed on 10/13/21.

On 10/12/21, the Pathology Coordinator (PC) in the ME's Office stated there were no signs of trauma observed. There was some bruising observed which was most likely due to CPR being administered. The ME was awaiting the results of several tests before a definitive cause and manner of death could be provided.

On 10/13/21, a new Article Ten Neglect petition was filed in Family Court. Both SSs were placed in kinship foster care with the MGM. ACS informed the foster care agency the service plan for the SM and SF was parenting and individual therapy.

On 12/5/21, ACS unsubstantiated the DOA/Fatality allegation. However, the Investigation Conclusion Narrative reflected it was substantiated. The narratives also supported the substantiation. ACD documented the SM and SF created the environment that led to the death of the SC by putting him in the tub of water and asking the 3-yo SS to care for the SC.

The SM said she left the SC in the tub while she cleaned the home. The SM was on the phone with a relative at the time the SC was alone in the tub. ACS also documented the SF knew and was present when the SM put the SC in the tub and asked the 3-yo to care for the SC. The SF admitted he was in the room but never checked the SC as he was "too busy" trying to put the 4-month-old to sleep.

ACS substantiated the allegations of IG and LS of the SC and 3-yo, and IG of the 4-month-old by the SM and SF. ACS documented the SM failed to provide adequate guardianship of the 3-yo by asking him to care for the SC in a tub of water. The 4-month-old was present and was derivatively in imminent risk or danger. The SF failed to provide adequate supervision of the SC

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
Sufficient information was gathered to make a determination for all allegations on the intake report.

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:
On 10/7/21, ACS opened a service case.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Supervisor Review

Summary:	The Allegation Information of the CPS Investigation Summary of the 10/6/21 fatality report reflected that the allegation of DOA/Fatality was Unsub. However, the Investigation Conclusion Narrative reflected that the allegation of DOA/Fatality was Sub.
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.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP was inadequate. The RAP reflected that there was no unstable housing or no housing. The documentation reflected the family resided in 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/06/2021 **Time of Death:** 04:32 PM

Time of fatal incident, if different than time of death: 03:00 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? No
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: In the bathtub

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☒ Distracted
- ☐ Absent
- ☐ Asleep
- ☐ Other:

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	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Month(s)

LDSS Response

On 10/6/21, the emergency room Dr. told ACS the SC arrived at the hospital and was pronounced dead at 4:32PM. When the SC arrived, he was in cardiac arrest.

On 10/6/21, EMS reported being at the building for a different family initially. The SM was observed running through the hall stating the SC was not breathing. When they went to the family's unit, EMS found the SF performing CPR.

ACS interviewed the SM and SF on 10/6/21. The SM stated she left the home at 2:15PM to pick up the 3-yo SS from school and returned home at about 2:31PM. The SF said the SM came home and saw feces in the bed, and she ran the tub to clean the SC. The SM said she placed the SC in the tub while the water ran, and she went to get a cup of water to clean the bed. The SC was in the tub and the water was still running. The 3-yo SS was in the room getting undressed. The SM said she returned to the bathroom to turn the water off and returned to clean the bed. A few minutes later when she returned to the bathroom she observed the child under water in the tub. The SM said she screamed, picked up the SC, and brought him out of the tub.

The SF said he took the SC from the SM, placed him on the bed, and checked for a pulse. When he did not feel a pulse, he placed the SC on the floor and began CPR. The SM called 911 and while she was on the phone she noticed there was an EMS ambulance outside. The SM ran to the ambulance for assistance while he continued CPR on the child. When the technicians arrived, they resumed CPR then transported the SC to the hospital. The SF said the water was about four inches high in the tub.

The MGM denied clinical health concerns for the SM and denied there was any substance abuse. Later, the MGM informed ACS she wanted to be a resource for the SSs.

On 10/6/21, the 3-yo told ACS he was with the SC who was sitting in the water and then he made a wave motion going under the water with his hand to state that he slipped under the water and then he saw the SC was sleeping under the water. He said he did not tell the SM and SF. ACS assessed that the SSs were in imminent danger if they were to remain in the care of the SM and SF. ACS placed the SSs in protective custody.

On 10/7/21, the MA stated she spoke with the SM ten minutes prior to the incident. Twenty minutes later, the SM called her to tell her the SC was not breathing, and they were on their way to the hospital.

On 10/7/21, ACS saw the children in the lobby of their building. The mother would not permit ACS in her home. The mother said her only concern was the SF did not visit the twins consistently.

On 10/7/21, the mother of the 10-yo said the SF did not know where she and the CH resided and would like to keep it that

way. ACS attempted subsequent video conference contacts but was unsuccessful.

On 10/7/21, the shelter case manager (CM) said she was assisting the family to locate housing. The CM told ACS the SM was very compliant with the policies and regulations of the shelter. The SM was very attentive to the CHN, and was always with them.

On 10/8/21, ACS spoke with the SF at the MGM's home. The SF and SM declined to discuss the incident on the advice of their attorneys. The SF and SM denied drug and/or alcohol use. ACS saw the SSs and assessed them to fine.

On 10/12/21, the Pathology Coordinator (PC) in the ME's office stated there were no signs of trauma observed. There was some bruising observed which was most likely due to CPR being administered. The ME was awaiting the results of several tests.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to 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
059792 - Deceased Child, Male, 1 Yrs	059793 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
059792 - Deceased Child, Male, 1 Yrs	059793 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
059792 - Deceased Child, Male, 1 Yrs	059793 - Mother, Female, 23 Year(s)	Lack of Supervision	Substantiated
059792 - Deceased Child, Male, 1 Yrs	059794 - Father, Male, 32 Year(s)	DOA / Fatality	Unsubstantiated
059792 - Deceased Child, Male, 1 Yrs	059794 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
059792 - Deceased Child, Male, 1 Yrs	059794 - Father, Male, 32 Year(s)	Lack of Supervision	Substantiated
059795 - Sibling, Male, 4 Month(s)	059793 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
059795 - Sibling, Male, 4 Month(s)	059794 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
059796 - Sibling, Male, 3 Year(s)	059793 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated

059796 - Sibling, Male, 3 Year(s)	059793 - Mother, Female, 23 Year(s)	Lack of Supervision	Substantiated
059796 - Sibling, Male, 3 Year(s)	059794 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
059796 - Sibling, Male, 3 Year(s)	059794 - Father, Male, 32 Year(s)	Lack of Supervision	Substantiated

CPS Fatality Casework/Investigative Activities

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

Explain:
Sufficient information was gathered to assess risk to all surviving children in the household.

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 10/6/21, the SSs were removed from the care of the SM and SF. On 10/13/21, an Article Ten Neglect petition was filed in family court. A remand was granted for the SSs. The two SSs were placed in kinship foster care with the MGM.

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:**
10/13/2021	There was not a fact finding	There was not a disposition
Respondent:	059793 Mother Female 23 Year(s)	

Comments:	On 10/13/21, ACS filed an Article Ten Neglect petition in Family Court naming the SM and SF as respondents. The SSs were placed in kinship foster care with the MGM.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The SF declined drug testing and certified alcohol and substance abuse counselor (CASAC) services. On 11/3/21, ACS submitted an Early Intervention referral for the 4-month old SS. On 11/15/21, ACS informed the foster care agency the service plan for the SM and SF was parenting and individual therapy.

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 SSs were placed in Kinship foster care with the MGM. On 11/3/21, ACS submitted an Early Intervention referral for the 4-month old SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SF declined drug testing and certified alcohol and substance abuse counselor (CASAC). On 11/15/21, ACS informed the foster care agency the service plan for the SM and SF was parenting and individual therapy.

History Prior to the Fatality

Child Information

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

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)
10/04/2020	Other Child - cousin, Female, 9 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	No
	Other Child - cousin, Female, 9 Years	Aunt/Uncle, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 9 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 9 Years	Father, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - cousin, Female, 9 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - cousin, Female, 9 Years	Aunt/Uncle, Female, 25 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - cousin, Female, 9 Years	Father, Male, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 2 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Years	Aunt/Uncle, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Years	Father, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Male, 2 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 2 Years	Aunt/Uncle, Female, 25 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 2 Years	Father, Male, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 5 Months	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 5 Months	Aunt/Uncle, Female, 25 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 5 Months	Grandparent, Female, 52 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 5 Months	Father, Male, 31 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 5 Months	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 5 Months	Aunt/Uncle, Female, 25 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 5 Months	Father, Male, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
The 10/4/20 SCR report alleged that the mothers (SM and MA) and the SF drank alcohol and smoked marijuana at times and became impaired while caring for the cousin, 2-yo CH, and SC. When impaired the SM and MA and the SF failed to tend to the CHN's needs, leaving them crying and fending for themselves. The MA and SF sold marijuana from the home via social media. The marijuana was accessible to the 2-yo and 7-yo cousin. The MA and the SF were gang affiliated, wore red bandanas to show their affiliation, and dressed the CHN in gang colors. The report also alleged the SF often slapped the 2-yo CH; the last incident occurred two days prior to the 10/4/20 report.

Report Determination: Unfounded | **Date of Determination:** 12/02/2020

Basis for Determination:
ACS unsubstantiated the allegations of the report on the basis of no credible evidence. ACS documented the parents, other adults, and children denied the allegation and no evidence was observed during the investigation

OCFS Review Results:
The report was initiated in a timely manner and pertinent collaterals were contacted. There was evidence of supervisory involvement.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/05/2019	Sibling, Male, 2 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The 12/5/19 SCR report alleged that at the end of October 2019, the SM repeatedly punched the father while the father was holding the 2-yo CH. The father turned his back to the SM to keep the 2-yo protected.

Report Determination: Unfounded | **Date of Determination:** 02/03/2020

Basis for Determination:
ACS unsubstantiated the allegations of the report on the basis of no credible evidence that the child was injured. However, NYCRO does not agree with the decision.

OCFS Review Results:
The SM confirmed there was intimate partner violence that occurred in October 2019 between herself and the father. According to the SM, the father attacked her and attempted to take the 2-yo CH from her. SM admitted to hitting the father on his back while he was holding a sleeping 2-yo in an attempt to prevent him from taking the 2-yo CH. According to the SM, the 2-yo was asleep during the incident. There was a domestic incident report (DIR) documented for this incident on 10/6/19. As per the DIR, the SM and father had a verbal dispute and they both slapped and pushed one another. On the report, it was noted neither party had any injuries.

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

Issue:
Appropriateness of allegation determination

Summary:
ACS did not incorporate information to make the determination for the allegation of IG. The documentation reflected the SM admitted to hitting the father on the back while he held the 2-yo, sleeping in the park with the 2-yo, and being around the father when they had an active OP.

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

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)
06/30/2019	Sibling, Male, 1 Years	Mother, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 1 Years	Mother, Female, 21 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The 6/30/19 SCR report alleged that out of anger, the SM, hit the 1-yo with her hands on his back, legs, and arms. As a result, the 1-yo sustained welts.

Report Determination: Unfounded **Date of Determination:** 08/14/2019

Basis for Determination:
ACS unsubstantiated the allegations on the basis of no credible evidence. ACS staff did not observe any signs of abuse or neglect in the home. The 1-yo was free from marks or bruises. The SM and collaterals denied the allegations. The 1-yo was free from marks and bruises during the course of the investigation.

OCFS Review Results:
ACS conducted the investigation with the parameters of SSL. Appropriate notices were provided and there was evidence of supervisory involvement.

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

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

The SF was known to the SCR and ACS as a subject in one report dated 3/3/17. The SF was listed as the Parent Substitute (PS). The allegations of the 3/3/17 report were IG and PD/AM of the 4-yo male CH by the SF and mother, IF/C/S of the 4-yo by the mother, and IG of the 4-yo by the grandparent and biological father. On 5/10/17, ACS unfounded the report.

The SM was known to the SCR and ACS in two reports dated 5/6/18 and 5/8/18. The allegations of the 5/6/18 report were IG and LS of the now 3-yo SS by the SM and biological father. On 7/5/18, ACS substantiated the allegation of IG by the father and unsubstantiated the allegation of LS by the SM. The allegations of the 5/8/18 report were IG and LS of the now 3-yo SS by the SM. On 7/5/18, ACS unfounded the report.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Required Action(s)

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

Issue:	Adequacy of Child Protective Services casework contacts (open services)
Summary:	The Family Service Progress Notes reflected that during the month of November 2018 and March 2019, there was no case activity documented.
Legal Reference:	18 NYCRR 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.

Preventive Services History

On 5/12/17, ACS opened a service case as there was a need for appropriate sleeping accommodations. ACS placed an order for a crib. No FASPs were completed and the service case was closed 8/2/17.

During the 5/6/18 investigation, ACS opened a service case on 5/9/18. The initial FASP reflected that the father threw the now 3-yo (who was 6 months old at the time) at the SM and the SM's family reportedly intervened. On 5/11/18, ACS filed an Article Ten Neglect petition in court. An OP was issued against the father for the 3-yo. Agency supervised visits were ordered. The family service plan for the father included batterer's counseling and clinical health services. The SM's service plan included: DV services and housing Services. The CH's service plan included: child care services and case management services. The Family Service Progress Notes (FSPN) reflected the SM and father were referred for toxicology screening. The SM was engaged in parenting and DV services.

The 6/7/19 FASP reflected the 6-month-old CH and SM were residing in a DV shelter. The CH's attorney requested for ACS to end supervision as the father's whereabouts were unknown and asked that custody be granted to the mother. The Family Court requested the father be notified one more time before custody being granted to the SM. Supervision ended on 5/17/19 and the service case was closed.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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