Child Fatality Report

Report Identification Number: NY-19-012

Prepared by: New York City Regional Office

Issue Date: Aug 06, 2019

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 02/02/2019
Initial Date OCFS Notified: 02/04/2019

Presenting Information

The 2/4/19 SCR report alleged, on 2/2/19 the SC had a seizure around 3:30 AM. The SM called EMS. They arrived at the home and then transported the SC to the hospital. The SC was pronounced dead a short time later. The SM's failure to have the SC seen at his scheduled appointments had a negative impact on the SC's condition. The SC was born with Prader-Willi Syndrome, which was a genetic eating disorder involving low muscle tone. He also suffered from a history of seizures. He missed medical appointments with the medical specialist and therapists. The SM failed to make these appointments dating back to November 2018.

The SM suffered from mental health conditions. The SM had not been compliant with her mental health treatment or taking her required mental health medication as prescribed. As a result, the SM had been unstable, overwhelmed and not able to care for the SC and SS, ages: 16, 6, 8, and 11 years old.

Executive Summary

The 3-year-old medically fragile male child (SC) died on 2/2/19. The autopsy listed the cause of death as Complications of Prader-Willi Syndrome and the manner of death as Natural.

The allegations of the 2/4/19 report were IG and LMC of the SC and SS, ages: 16, 11, 8, and 5 years, and DOA/Fatality of the SC by the SM. At the time of the SC's death, the family had an open preventive services case.

ACS learned that on 2/1/19, the SC was fed about 9:00 PM. He acted normal and played with his siblings. He later fell asleep in the living room with the SM’s friend. The SC awoke at approximately 3:30 AM on 2/2/19. The SM's friend was in the home with the SC, and she woke the SM and alerted her that the SC was crying. The SM checked the SC, observed his eyes rolled towards the back of his head, and she immediately called 911. EMS arrived and attempted to resuscitate the SC. The SC was transported to the hospital where he was pronounced dead.

On 2/6/19, ACS placed the four SS into protective custody. ACS informed the SM that the SS were removed as there were concerns regarding the SS’s safety. ACS noted the 16-yo SS had a pre-existing medical condition and it was alleged the SM failed to monitor his medical needs. ACS addressed the concern regarding an injury the 16-yo SS sustained to his forehead and nose. This SS said he sustained the injury from falling outside. Regarding this SS's injury, the SM said the 16-yo SS became ill and fell while he was outside of the home, and he was transported to the hospital for medical care. ACS asked the SM about a burn injury that was observed on the SC’s stomach. The SM said she had no heat in the home for days and bought a space heater. She explained that she placed the heater by the bathroom to warm it before giving the SC a bath. The SC sustained the burn injury when he ran into the heater. The SM had a sixth child, but ACS did not include date of birth and whereabouts of this child in the case record.

On 2/7/19, the SS were temporarily placed with the SM's friend, who was willing to care for the four SS until a decision was made in Family Court in the Order to Show Cause hearing. On the same day, a conference occurred and the outcome was ACS would amend the petition in Kings County Family Court (KCFC). ACS would seek a remand of the SS. On 2/7/19, an Article Ten Neglect petition was filed and it was determined the SS would remain in the care of the friend. On 3/18/19, the judge returned the SS to the SM’s care.

On 3/21/19, ACS brought the three female SS to the CAC to assess for trauma. The 16-yo SS was not available at the

time. Bereavement counseling was recommended for the family.

On 4/5/19, ACS substantiated the allegations of LMC and IG of the SC and four SS by the SM. The 16-yo SS had a pre-existing medical condition and was non-compliant with his medication. The SM said she sometimes gave him medication and other times she let him take it on his own. The SM failed to address his behavior. The SM failed to replace the 11-yo SS's glasses which affected her negatively in school. The SM only acted after ACS intervened. The SM failed to take the SS for preventive dental care as a result she had cavities. The SC was seen by his physician in May 2018 and was referred to Early Intervention (EI), medical specialist, and developmental primary care physician (PCP). The SM did not follow through with the referral.

ACS unsubstantiated the allegation of DOA/Fatality. The ME performed an autopsy and listed the cause of death as complications to Prader-Willi Syndrome and the manner was ruled Natural.

The case remained open for preventive services at the time of issuance of this fatality report.

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:
The documentation reflected the family received PPRS through Community Counseling and Mediation, and court order supervision.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	The documentation reflected that the Notice of Existence was not mailed to the SC's BF until 2/13/19 which was not within seven days of the receipt of the 2/4/19 report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency 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:	The documentation did not reflect whether ACS offered housing assistance to the SM who was involved in housing court.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency 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 Progress Notes
Summary:	The documentation reflected that on 3/20/19, ACS spoke with the mother and she said that her son called her to inform her about the 16-yo SS. ACS did not obtain information about the SM's sixth child.
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/02/2019 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 03:30 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 03:51 AM
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: The child was alert.

Did child have supervision at time of incident leading to death? Yes
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	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	11 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	11 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Year(s)

LDSS Response

On 2/5/19, ACS interviewed the SM who said on 2/1/19, the SC played throughout the home. According to the SM's account, the SC ate dinner and about 11:00 PM, and she tried to him to sleep but he remained awake. On 2/2/19, the SC was in the living room with a SM's friend when the SM heard the SC call for assistance. The SM checked him and found he had trouble breathing. The SM called 911 and FDNY responded to the home. The SC vomited and aspirated. The SM informed ACS, with the exception of the 16-year-old SS, she did not want ACS to interview the SS. ACS attempted to interview the 16-yo SS who said he did not have anything to say. The SM's friend was in the home and became upset during the ACS visit.

Later, the friend said she was at the SM's home with her own children throughout the night. The friend said the children ate and went to sleep in the girls' room. The SC fell asleep next to her and she got up and spoke to the SM at around 1:30 AM. She returned to the living room and laid next to the SC. He looked at her, pointed and indicated he needed the SM. She called the SM on the phone and the SM came into the living room. The SM observed the SC and said he was ill. When the SM came to the living room, the SC stared and then his body had no movement. She called 911 and the SM spoke with EMS. She sat the SC in an upright position until EMS arrived.

ACS noted the SM was referred to mental health services and the physician prescribed medication. The SM was not compliant with the services or medication. The SM did not follow through with numerous referrals made by the PCP for the SC's medical condition. The 16-yo SS refused to participate in counseling and was inconsistent with taking prescribed medication for his condition.

On 2/5/19, ACS interviewed the ME's office and learned it was unclear whether an autopsy was scheduled. Later, ACS obtained information from the ME's office confirming an autopsy would be performed to put all concerns to rest.

On 2/5/19, the PCP said the SC became a new patient on 3/29/18. There family did not mention the SC's diagnosed medical condition at that time. Referrals were made for nutrition, dental, EI, and medical specialists. The SC was hospitalized from 4/3/18 to 4/6/18. A referral was made from the hospital for the SC to see a medical specialist. The physician said the referrals made were not kept although there was monthly follow up with the family with letters and telephone calls. He was seen in the clinic on 5/17/18. The physician was unable to state whether the history of medical neglect contributed to the SC's death.

On 2/6/19, ACS discussed the 16-yo SS's non-compliance with his medication. The SM stated she was unable to manage this SS's behavior. She said she reminded him provided supervision regarding his medication.

On 2/14/19, the friend informed ACS she would not be able to assist with supervision of the SS. The SM informed ACS that she was given a medical appointment for the 16-yo SS. The SM said she called to schedule medical appointments for all the SS, but they were seen in October 2018 and were not due for well-child examinations.

On 3/26/19, ACS conducted a joint home visit with NY Foundling. ACS and NY Foundling observed the four SS.

On 4/21/19 and 4/29/19, the SCR registered reports regarding the family. The allegations of the 4/21/19 report were IG and SA of a 14-yo female child by the child's mother and the SM. The report was indicated on 6/20/19. The allegations of the 4/29/19 report were SA and IG. The report was unfounded 6/26/19. A new report was registered on 8/1/19 with allegations of IG and SA of the 16-yo SS. The investigation is ongoing.

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: There is no OCFS approved Child Fatality Review Team in NYC.

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
050421 - Deceased Child, Male, 3 Yrs	050422 - Mother, Female, 32 Year(s)	Lack of Medical Care	Substantiated
050421 - Deceased Child, Male, 3 Yrs	050422 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
050421 - Deceased Child, Male, 3 Yrs	050422 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
050423 - Sibling, Male, 16 Year(s)	050422 - Mother, Female, 32 Year(s)	Lack of Medical Care	Substantiated

050423 - Sibling, Male, 16 Year(s)	050422 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
050424 - Sibling, Female, 5 Year(s)	050422 - Mother, Female, 32 Year(s)	Lack of Medical Care	Substantiated
050424 - Sibling, Female, 5 Year(s)	050422 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
050425 - Sibling, Female, 8 Year(s)	050422 - Mother, Female, 32 Year(s)	Lack of Medical Care	Substantiated
050425 - Sibling, Female, 8 Year(s)	050422 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
050830 - Sibling, Female, 11 Year(s)	050422 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
050830 - Sibling, Female, 11 Year(s)	050422 - Mother, Female, 32 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐
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 2/7/19, ACS filed an Article Ten Neglect petition in Kings County Family Court. The documentation reflected that on 2/7/19, ACS filed a motion to change the status of the SS from court ordered supervision to remand. An Order to Show Cause hearing was initiated on 2/8/19. The judge returned the SS to the SM's care on 3/18/19.

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:**
02/07/2019	There was not a fact finding	There was not a disposition
Respondent:	050422 Mother Female 32 Year(s)	
Comments:	On 2/7/19, ACS filed an Article Ten Neglect petition in Kings County Family Court. The Family Court ordered that the SM and BF were allowed to stay at the family friend's home with the SS for one night. The family friend would supervise all contact between the SM and SS. The BF was ordered not to be under the influence of substances during visitation with the SS. The documentation reflected that on 2/7/19, ACS filed a motion to change the status of the SS from court ordered supervision to remand. An Order to Show Cause hearing was initiated on 2/8/19. On 3/18/19, the SS returned to the SM's care. Family Court ordered the SM to make best efforts to ensure the 16-yo attend school daily, the SM continue to comply with PPRS and their recommendations, MST-CANS be put in place immediately, the SM was ordered to receive mental health treatment and the SS receive individual counseling through MST-CAN, but if not other referrals, and the SM to ensure the four SS attend school every day and on time.	

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: PPRS							
Additional information, if necessary: The family received ACS court ordered supervision.							

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 11-yo, 8-yo and 5-yo were assessed for trauma at the CAC.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS referred the SM for mental health services. The SM and her family were involved with PPRS at the time of the fatality. ACS provided the family friend who was caring for the SS with financial assistance.

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)
08/09/2018	Sibling, Female, 8 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes
	Sibling, Female, 8 Years	Aunt/Uncle, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 16 Years	Mother, Female, 31 Years	Sexual Abuse	Unsubstantiated	
	Sibling, Male, 16 Years	Aunt/Uncle, Female, 30 Years	Sexual Abuse	Unsubstantiated	
	Sibling, Male, 16 Years	Father, Male, 32 Years	Sexual Abuse	Unsubstantiated	

Sibling, Male, 16 Years	Aunt/Uncle, Female, 30 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 16 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 16 Years	Father, Male, 32 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 16 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 11 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 11 Years	Father, Male, 32 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 11 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 11 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 11 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Years	Mother, Female, 31 Years	Sexual Abuse	Unsubstantiated
Sibling, Female, 11 Years	Aunt/Uncle, Female, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 11 Years	Aunt/Uncle, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Years	Aunt/Uncle, Female, 30 Years	Sexual Abuse	Unsubstantiated
Sibling, Female, 11 Years	Father, Male, 32 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 11 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Years	Father, Male, 32 Years	Sexual Abuse	Unsubstantiated
Sibling, Female, 8 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 8 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 8 Years	Aunt/Uncle, Female, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 8 Years	Father, Male, 32 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 6 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 6 Years	Father, Male, 32 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 6 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 6 Years	Aunt/Uncle, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 6 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Male, 16 Years	Mother, Female, 31 Years	Lack of Supervision	Substantiated
Sibling, Male, 16 Years	Father, Male, 32 Years	Lack of Supervision	Substantiated
Sibling, Male, 16 Years	Aunt/Uncle, Female, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 16 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Sibling, Male, 16 Years	Aunt/Uncle, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Years	Aunt/Uncle, Female, 30 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 11 Years	Mother, Female, 31 Years	Lack of Supervision	Substantiated
Sibling, Female, 11 Years	Father, Male, 32 Years	Lack of Supervision	Substantiated
Sibling, Female, 11 Years	Aunt/Uncle, Female, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 11 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 11 Years	Aunt/Uncle, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 6 Years	Aunt/Uncle, Female, 30 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 3 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 3 Years	Father, Male, 32 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 3 Years	Father, Male, 32 Years	Parents Drug / Alcohol Misuse	Substantiated
Deceased Child, Male, 3 Years	Aunt/Uncle, Female, 30 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 3 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 3 Years	Aunt/Uncle, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
The 8/9/18 report alleged the BM, BF and unrelated home member were under the influence of marijuana, cocaine, pills and alcohol while caring for there SS and three unnamed children, ages: 7, 6, and 2 years old. The adults made poor decision for the safety and well being of the children. The adults allowed a 15-yo child and 15-yo SS to engage in sexual activities. The 15-yo SS sexually touched the 11-yo SS in the past. The BF was not supposed to be around children as his children, including the 15-yo child, were removed from his care. The adults allowed the 11-yo SS to stay in the streets late at night until 3:00 AM.

Report Determination: Indicated | **Date of Determination:** 10/01/2018

Basis for Determination:
ACS unsubstantiated the allegations of IG, PD/AM and SA of the subject children by the unrelated home member on the basis the unrelated home member did not have caretaker responsibility for the children. ACS unsubstantiated the allegation SA as the CAC forensic interviews showed there was no evidence of sexual abuse. ACS unsubstantiated the allegation of PD/AM by the SM as the SM had negative results for drug use.

ACS substantiated the allegations IG and LS of the SC and SS by the SM and BF, and PD/AM by the BF on the basis the SM and BF did not follow up with the children's medical needs and provided poor child supervision. The BF's drug misuse had a negative impact childcare activity.

OCFS Review Results:
ACS interviewed the SM and BF. The SM denied the 16-yo SS touched the 3-yo SS or interacted with any of the children in a sexual manner. According to the SM, when she was out of the home, the MA and MGF assisted with supervision of the SS. She said she complied with PPRS. She denied drug/alcohol use. The BF said the 11-yo SS was touched by her

half-sibling when visiting her father's home two years ago. He said the SM contacted the CP and addressed the incident.

ACS found there were concerns of lack of follow through with the medical appointments. On 9/10/18, ACS filed an Article Ten Neglect petition in Family Court, and a temporary OP was issued for the BF regarding the SC and four SS.

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

Issue:

Pre-Determination/Supervisor Review

Summary:

The supervisory review was inadequate as there was a lack of directive regarding persons legally responsible for the children named in the report. The CPS Investigation Summary reflected ACS substantiated the allegation of IG of the 8-yo SS by the unrelated home member. However, in the Investigation Conclusion Narrative ACS unsubstantiated the allegation of IG of the 8-yo SS.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/11/2018	Sibling, Female, 5 Years	Mother, Female, 31 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Female, 11 Years	Mother, Female, 31 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 15 Years	Father, Male, 33 Years	Educational Neglect	Substantiated	
	Sibling, Male, 15 Years	Father, Male, 33 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 15 Years	Father, Male, 33 Years	Lack of Medical Care	Substantiated	
	Sibling, Male, 15 Years	Mother, Female, 31 Years	Educational Neglect	Substantiated	
	Sibling, Male, 15 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 15 Years	Mother, Female, 31 Years	Lack of Medical Care	Substantiated	
	Sibling, Female, 7 Years	Mother, Female, 31 Years	Educational Neglect	Substantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 31 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:

The 4/11/18 report alleged that on an on-going basis, the SM and parent substitute failed to administer the 15-yo SS's medication. As a result, the 15-yo SS became ill in November of 2017 and the again on 3/9/18. The 15-yo SS had excessive school absences including not attending from 12/24/17 through 4/6/18, and he failed classes as a result. The SM and parent substitute were aware and failed to ensure the 15-yo SS attended school.

Report Determination: Indicated | **Date of Determination:** 06/09/2018

Basis for Determination:
ACS found that the SM failed to ensure the 15-yo, 7-yo, and 5-yo children's needs were being met as she and the parent substitute had a pattern of not ensuring the children attended school on a consistent basis. Due to the children's excessive absence from school they did not meet grade requirements based on information provided by the school. The SM and parent substitute failed to meet a minimum degree of care for the 15-yo SS by their actions and not ensuring the children's medical needs and educational needs were met. The SM and parent substitute were aware the 15-yo SS had a medical condition, but missed two appointments.

OCFS Review Results:
The SM informed ACS that she took the 15-yo to the Dr. and he took his medication. ACS observed the 15-yo's medication. The SM said on 12/25/18, the 15-yo SS was hit by a car and sustained a fractured arm and leg leaving him unable to attend school. He returned to school on 4/9/18. The school provided documentation for home schooling, but the 15-yo SS was not qualified. The BF of the SC said they took the children to the medical appointments. The 15-yo SS said he was hit by a car and said his leg was broken. ACS noted this SS said he attended scheduled appointments twice a month. The preventive services worker told ACS that the 15-yo SS was ill twice as his medication level was zero.

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

Issue:
Pre-Determination/Supervisor Review
Summary:
The supervisory review was inadequate as ACS unsubstantiated the allegation of EdN of the 5-yo, but did not include a justification narrative. ACS added the allegation of EdN of the 5-yo and 7-yo SS by the BF to the report. However, ACS did include the EdN allegation in the Allegation Information details.
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:
Timely/Adequate Seven Day Assessment
Summary:
The 4/18/18 safety assessment document was inadequate as ACS did not include the caretakers' inability or unwilling to provide adequate care and/or protection of the SC and SS.
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:
Assessment as to need for Family Court Action
Summary:
ACS did not obtain Family Court Legal Service consultation to assess the need for Family Court action.
Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(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:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The 6/9/18 safety assessment document was inadequate as it did not reflect the vulnerability, parent/caretaker was unable or unwilling to provide adequate care and/or protection of the child(ren).
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)
12/07/2017	Sibling, Male, 15 Years	Mother, Female, 31 Years	Lack of Medical Care	Substantiated	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 31 Years	Lack of Medical Care	Substantiated	

Report Summary:
The 12/7/17 report alleged the 15-yo SS was ill and required medication to prevent his illness. On 11/13/17, the 15-yo SS was ill due to him not taking his medication as needed. The SM failed to ensure the 15-yo SS took his medication. Since then, there had been no evidence that the SM refilled his medication as prescribed.

The SC was diagnosed with Prader-Willi Syndrome, which affected his growth and development. The SC was supposed to be taken to a specialty hospital for regular checkups. The SC had not been to the hospital since January 2017.

Report Determination: Indicated | **Date of Determination:** 02/12/2018

Basis for Determination:
The 15-yo was medically fragile in that he suffered from an illness. The 15-yo SS said he had not taken his medication since August 2017. In November 2017, the 15-yo SS became ill and was found to have no medication in his system. The SM was aware the 15-yo SS was not taking his medication and took no further action to address the matter. ACS observed the 15-yo SS's medication and found it expired. The physician diagnosed the SC with Prader-Willi Syndrome. The SC was in need of Early Intervention (EI) services as a result. The SC's EI service ended because the SM failed to complete the necessary documentation to continue the services.

OCFS Review Results:
On 12/7/17, PPRS informed ACS the 15-yo had a medical condition and the SM was not able to ensure he took his prescribed medications. On 11/13/17, the 15-yo SS was ill and did not have medication in his system. The SM did not enforce the 15-yo SS taking his medication. The 15-yo SS said he did not take his medication. The SC was diagnosed with Prader-Willi Syndrome and was in need of EI services. The SM did not take the SC for follow up medical examination and failed to complete documentation so he could resume services. The SM told ACS the 15-yo SS refused to take the medications. Regarding EI services, the SM said she repeatedly asked the physician to complete his documentation.

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

Issue:
Required data and official documents
Summary:

The CPS Investigation Summary did not include updated information as the 7-yo SS's address. This SS was listed as a member of the household composition.

Legal Reference:

428.3(b)(2)(i)

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 Seven Day safety assessment document was inadequate. ACS did not select the safety factor regarding the SC and 15-yo SS's significant vulnerability, medical needs and the SM and BF's inability or unwillingness to provide adequate care and/or protection of the SS.

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 2/12/18 safety assessment document was inadequate. ACS did not select the safety factor regarding the caretakers' inability or unwillingness to provide adequate care and/or protection of the SC and SS.

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.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

The family changed physician during the investigation, but did not contact the initial physician to verify the SM's statement about completing required documentation. ACS did not interview neighbors regarding the family's home and to obtain information pertaining to allegations about hazardous health condition in the building.

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)
06/13/2016	Deceased Child, Male, 1 Years	Mother, Female, 29 Years	Lack of Supervision	Unsubstantiated	Yes
	Deceased Child, Male, 1 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 13 Years	Mother, Female, 29 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 29 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 5 Years	Mother, Female, 29 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 29 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 13 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 5 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 9 Years	Father, Male, 30 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
The 6/13/16 report alleged the SM and her male paramour failed to supervise the SC and SS. The children allegedly ran out of their apartment to the outside of the building with no adult supervision. They went to the park without any supervision. On 6/12/18, the children were in the park without adult supervision for an unknown period of time. The 13-year-old male SS was believed to have clinical health issues, and was described as a menace in the neighborhood. The situation had been going on since the last winter.

Report Determination: Unfounded **Date of Determination:** 08/12/2016

Basis for Determination:
The SC was medically fragile, could not be left alone, and the BF or SM was always present to provide supervision for the SC. During the home visits, ACS observed the SM and BF attended to the SC's needs. The 5-yo and 9-yo SS said an adult cousin assisted with their supervision during visits to the park or other outdoor activities. The CP confirmed the SC and SS received adequate adult supervision.

OCFS Review Results:
On 6/13/16, the 9-yo SS said one of her parents was always at home to supervise the SS. She said the BF allowed the SS to visit next door to play while checking them every 15 minutes. The 5-yo SS said the BF permitted them to go to the park to play but continued to monitor their activities. She denied strangers visited the home. The 3-yo SS said she went to the park with her older SS. She could not tell ACS the location of the SM and BF. The 13-yo SS said an older cousin always accompanied the children to the park visits.

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

Issue:
Pre-Determination/Supervisor Review

Summary:
The Investigation Conclusion Narrative of the 6/13/16 report was incomplete as it did not address the allegation of LS of the two subject children, ages: 3 and 13 years.

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:
Timely/Adequate Seven Day Assessment

Summary:

The Seven Day safety assessment document was inadequate as it included an associated comment that did not reflect the SM placed the children in immediate or impending danger. The associated comment showed ACS did not determine how the SM's condition impacted her ability to supervise and protect the children. ACS explained that the agency was unable to interview the SM.

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 8/12/16 safety assessment document was inadequate as it did not include information ACS received from a physician on 7/20/16. According to the Investigation Progress Notes, ACS learned the frequency of the medical visits were insufficient to track the child's medical needs. There were health concerns related to changing of the SC's feed tube.

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)
03/02/2016	Sibling, Female, 5 Years	Father, Male, 31 Years	Educational Neglect	Unsubstantiated	Yes
	Deceased Child, Male, 9 Months	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 9 Months	Mother, Female, 29 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 5 Years	Mother, Female, 29 Years	Educational Neglect	Unsubstantiated	

Report Summary:

The 3/2/16 report alleged the SC was a medically fragile child. The SC had private duty nursing care in the home until January when the SM began refusing the care. The SM did not follow up with the SC's physician since before December 2015. The SC was at risk for significant problems without consistent medical care. The SM was previously overwhelmed with the care of the SS (ages 12 and under) and could not reasonably provide adequate care for the SC.

Report Determination: Unfounded | **Date of Determination:** 05/03/2016

Basis for Determination:

ACS noted there was no credible evidence to prove the SM failed to provide the SC and SS with their minimum basic needs. The SM was compliant with preventive services. The SC was examined by his physician. The CP made arrangements to reinstate nursing services for the SC. ACS interviewed the SM and SS and found the SM encountered challenges but eventually enrolled the SS in school. There was no credible evidence to prove the BF of the 5-yo SS failed to provide this SS with her overall basic needs.

OCFS Review Results:

The SM denied the allegation of the 3/2/16 report. The SM said she was not overwhelmed with the care of the SC and

SS. She said she had a good support system. The SM believed she was able to care for the SC and did not need the visiting nurse services. The SM completed feeding classes at the hospital. She said she also had support through PPRS.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The Seven Day safety assessment was inadequate. An associated comment did not support the safety factor that stated the parents/caretaker were unable and/or unwilling to provide adequate care and/or protection of the children.
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 5/3/16 safety assessment was inadequate. ACS included and associated comment that stated both children received appropriate medical care. ACS did not identify any safety factor that placed the children in immediate or impending danger.
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.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
The documentation did not reflect ACS attempted to interview the 5-yo SS's father, who was a subject of the 3/2/16 report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
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 Progress Notes
Summary:
The documentation did not reflect ACS adequately documented the interview with the SC's physician. The documentation reflected on 3/3/16, the SM was interviewed regarding the physician's statements and directives, but the physician's interview with ACS was not included in the Investigation 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:
Contact/Information From Reporting/Collateral Source
Summary:
ACS documentation did not reflect ACS asked the SC's physician about the medical examinations that reportedly occurred prior to December 2015 and if the delay in obtaining subsequent examinations resulted in lack of medical care of the SC.
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.

Issue:
Overall Completeness and Adequacy of Investigations
Summary:
During the 3/2/16 investigation, the SCR registered a report on 4/5/16. ACS consolidated the 4/5/16 report into the 3/2/16 investigation. The ACS documentation did not include the SM and SS's accounts regarding the allegation of EdN of the 5-yo SS.
Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)
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.

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

Between 7/15/09 and 7/22/15, the SM was listed as a subject in 14 reports pertaining to her children.

The reports dated 7/29/10, 12/23/10, 12/24/10, 1/13/14, 4/11/14, 11/5/14, and 7/22/15 included combined allegations of IG, PD/AM, DOA/Fatality, B/S, LS, EdN, IF/C/S, CD/A, and LMC. ACS indicated these reports.

The 12/23/10 report also pertained to the SM's 4-month-old niece who died on 12/23/10. ACS found that due to a lack of supervision of the niece and other children, the SM and mother of the niece were not aware of the niece's location, thereby causing her to die in a fire. On 6/23/11, OCFS issued Child Fatality Report 95-2010-00084 pertaining to the niece's fatality.

The allegations of the 7/15/09, 3/22/10, 2/8/12, 6/22/12, 9/10/12, 1/7/13, and 7/19/14 reports were a combination of IG, IF/C/S, PD/AM, LS, L/B/W, and EdN. ACS unsubstantiated all the allegations of these reports.

The 11-yo SS was known as a confirmed maltreated child in a report dated 2/24/15. The allegations of the report were EdN, LS, and IG. The father of the 11-year-old SS was a subject of this report. The report was indicated.

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: 03/11/2014

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: 03/11/2014

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☐	☒	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☐	☒	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine

Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

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

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 1/13/14 investigation, ACS opened a preventive services case on 3/11/14. ACS referred the family for PPRS to address mental health, medical and educational needs of the 16-yo, 11-yo, 8-yo, and 5-yo SS. The family was received PPRS with Community Counseling and Mediation (CCM).

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The CCM Family Service Progress Notes were not entered contemporaneously. An event occurred on 6/1/16, but was not entered until 7/29/16.
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:	Contact/Information From Reporting/Collateral Source
Summary:	The CCM notes reflected the SC received therapeutic services in the home. Between 10/10/16 and 4/28/17, the CCM Family Service Progress Notes did not reflect these service providers were contacted.
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.

Issue:	Assessment of Services and Maintaining Records
Summary:	CCM did not assist the family with obtaining home attendant services to support the SM with care of the SC who had developmental disabilities.
Legal Reference:	18 NYCRR 428.1(a)(2) and 428.3(a)
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 Monitor
Summary:	The ACS Family Service Progress Notes did not reflect ACS successfully conducted a home visit in November 2018; the family had ACS court ordered supervision.
Legal Reference:	18 NYCRR 432.2(b)(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.

Preventive Services History

Between 2010 and 2013, the family received preventive services to address the SM's drug misuse and mental health needs. The SM completed parenting classes, individual counseling sessions and substance abuse program. During the 12/23/10 investigation, ACS filed an Article Ten Neglect petition against the SM and MA, and obtained court ordered supervision (COS). On 5/2/12, COS ended; however, the preventive services case remained open. ACS closed the case after the family complied with all requirements.

During the 1/13/14 investigation, ACS opened a preventive services case for the family on 3/11/14. The family received mental health, medical and educational services. The 10/10/15 FASP reflected the family received services through Community Counseling and Mediation (CCM). The documentation showed there were concerns about the SM's ability to care for the SC. On 9/10/18, ACS filed an Article Ten Neglect petition in Family Court on behalf of the SC and SS.

ACS staff visited the home on 1/15/19 and observed the SC walk around and play with his four SS. The CP's last home visit occurred on 1/25/19. The CP noted the SC had sustained a burn injury to the stomach. The SM said the injury was caused by an electric heater. The SM discarded the heater and applied medication to the injury.

ACS did not complete the required number of court ordered supervision casework contacts.

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:**

09/10/2018	There was not a fact finding	There was not a disposition
Respondent:	050422 Mother Female 32 Year(s)	
Comments:	The ACS documentation reflected that on 9/10/18, ACS filed an Article Ten Neglect petition naming the SM and BF as the respondents. There were concerns the BF misused drugs. There were also concerns the SM failed to follow up with the SC, 16-yo, 8-yo, and 1-yo SS's medical needs.	

Have any Orders of Protection been issued? Yes	
From: 09/10/2018	**To:** Unknown
Explain: The Family Service Progress Notes reflected that on 9/10/18, a temporary OP was issued agaisnt the BF regarding the SC and four SS.	

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