Child Fatality Report

Report Identification Number: NY-20-083

Prepared by: New York City Regional Office

Issue Date: Mar 09, 2021

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: 3 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 09/13/2020
Initial Date OCFS Notified: 09/13/2020

Presenting Information

The initial report alleged at an unknown time in the recent past, the mother found the child unresponsive and blue when she got out of the shower. At an unknown time after this, the mother called 9-1-1. It is unknown what happened while the mother waited for emergency medical services. However, as they were taking too long, the mother then drove the child to the hospital herself. Upon arrival to the hospital, emergency medical technicians immediately began cardiopulmonary resuscitation on the child. The child presented with a hematoma on his forehead and a fractured clavicle. After life saving measures failed, the child was pronounced dead. The mother provided no reasonable explanation for his death or condition.

A subsequent report alleged on 9/12/2020 between 3:00PM and 4:30PM, the mother got out of the shower to find the 3-month-old child unconscious, not breathing, and blue. The mother brought the child to the hospital where cardiopulmonary resuscitation was immediately administered. The child was later pronounced dead on 9/13/2020 at 10:00AM. The mother had no explanation for the death of the child. After the child was brought to the hospital, it was determined that the child had a broken clavicle, a hematoma, and swelling to the forehead. There was no explanation for the injuries. The role of the unknown father was unknown.

Executive Summary

This three-month-old male child died on 9/14/20. The Medical Examiner has not provided the final cause and manner of death; however, contact with the ME on 9/14/20 revealed the child did not have any broken clavicle bones, bruising, or hematomas to the head or about the body. According to the ME the only injuries observed were broken ribs which was consistent with medical personnel performing CPR on the child. Examination of the child's body showed the child was "structurally fine" and there were no concerns or suspicions that the child was physically being abused; the cause of death was pending further tests.

On the date of the child's death the SCR registered two reports with allegations of DOA/Fatality, Fractures, Swelling, Dislocation, Sprains and Inadequate Guardianship of the child by the mother.

At the time of the child's death, he resided with his mother, and four siblings. ACS's investigation revealed The mother stated that around sometime between 4:00PM and 4:30PM she placed the child inside of the bassinet (with the Boppy pillow inside) and went into the bathroom. The mother stated that her niece also went into the bathroom with her and was sitting on the toilet. The mother stated that she took her phone inside the bathroom and was in the bathroom for 5-10 minutes. The mother stated that when she exited the bathroom, she immediately checked the child and observed the child to be foaming at the mouth, and to have spit bubbles, and a little bit of blood was coming from the child's nose. The mother stated that upon finding the child in that condition, she left the home, jumped in her car, and drove the child to the hospital. The mother said she began the journey with the child in her arm, but eventually handed the child to her niece who was in the passenger seat. The mother stated that when she arrived at the emergency room she ran inside and screamed out for help. EMS workers, who were in the hospital, took the child from her, and immediately began CPR and other lifesaving actions. The child was revived and two hours later he died. The time of death was 12:51AM on 9/14/20.

From the time the investigation began to the time of its closure, ACS interviewed family members and pertinent collateral sources including hospital personnel, school officials and the children's pediatrician. Law enforcement found no criminality on behalf of the mother. During the course of the investigation ACS staff incorporated information obtained

from collaterals into their assessment of safety for the children. There was evidence of good investigative actions and reinforcement of safe sleep practices for infants. ACS provided the family with appropriate services referrals in response to the death of the child, including voluntary prevention services to address ongoing needs. ACS found no evidence the parents' actions or inaction caused the death of the child.

On 11/12/20, ACS unsubstantiated the allegations of DOA/Fatality, Swelling, Dislocation, Sprains, Fractures and Inadequate Guardianship of the child by the mother based on no credible evidence found to substantiate the allegations. To support the decision, ACS cited the preliminary report from the ME and other medical personnel, which stated the child had no marks, bruises, and there was no indication of abuse or maltreatment. The investigation was unfounded and closed.

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?** No
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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 determination for the allegations of the report. The safety decision recorded on the safety assessment at the time of the Investigation Determination was appropriate.

Was the decision to close the case appropriate? Yes

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

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

Explain:
The level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion, was commensurate with the case circumstances. There was documentation of supervisory consultation during the investigation. The decision to close the case appropriate.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/13/2020 **Time of Death:** 12:51 AM

Date of fatal incident, if different than date of death: 09/12/2020
Time of fatal incident, if different than time of death: 04:56 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was:

Total number of deaths at incident event:
Children ages 0-18: 01
Adults: 00

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Other Household 1	Father	No Role	Male	38 Year(s)
Other Household 1	Sibling	No Role	Female	22 Month(s)
Other Household 2	Sibling	No Role	Female	13 Year(s)

LDSS Response

Within the first 24 hours of the receipt of the report, ACS's Emergency Children's Services staff contacted the family and conducted an emergency removal. The children were medically seen at Children's Center where it was reported that three

younger children were reported to have lice. They were treated at the Children's Center. No medications prescriptions were provided for them.

On 9/14/20, ACS staff contacted the ME who disagreed with the removal of the sibling based on the fatality. The ME explained the SC had none of the reported injuries.

On 9/14/20, ACS staff spoke with medical personnel who stated the child was brought to the hospital by the mother. Upon arrival at the hospital the BM brought the child to EMS technicians who were on their lunch break. The child was then brought into the pediatric emergency room for medical assistance. The doctors were eventually able to establish a pulse for the child after performing CPR and with the use of epinephrine. The child was brought to the PICU at about 7:15PM and was pronounced dead at 12:51AM. The child underwent a CAT scan which showed that he was without oxygen for an extended period which resulted in Hypoxia. No broken clavicle bones, hematomas, or swelling were noted on the child's body.

On 9/14/20, ACS staff attempted to interview the parents while they were at the PGM's home. According to the case notes, the father became "very threatening" and demanded for the Specialist to leave the home; therefore, only a partial assessment of the home was completed. The mother stated that she and the surviving children would be returning to the family's residence on 9/15/20.

On 9/15/20, the mother was interviewed. The mother said on 9/13/20 she woke up between 10:00AM and 11:00 AM, and when she awoke, she observed the child to be fine. The mother stated that the father was in the home and had fed the child, changed his diaper, and clothed the child. The mother said the father eventually left the home and she was in the home with the five children and her 13-year-old niece.

The mother stated that her two youngest children were in their room, and her two eldest children were also in their room watching television. The mother stated that she had fed the infant and placed him inside of his mobile bassinet on top of his Boppy pillow. The Specialist documented the Boppy pillow was "considerably large" in comparison with the size of the mobile bassinet. The Specialist reviewed safe sleep information with the mother.

The mother stated that around sometime between 4:00PM and 4:30PM she placed the child inside of the bassinet (with the Boppy pillow inside) and went into the bathroom. The mother stated that her niece also went into the bathroom with her and was sitting on the toilet. The mother stated that she took her phone inside the bathroom and was in the bathroom for 5-10 minutes. The mother stated that when she exited the bathroom, she immediately checked the child and observed the child to be foaming at the mouth, and to have spit bubbles, and a little bit of blood was coming from the child's nose. The mother stated that upon finding the child in that condition, she left the home, jumped in her car, and drove the child to the hospital. The mother said she began the journey with the child in her arm, but eventually handed the child to her niece who was in the passenger seat.

The mother stated that when she arrived at the emergency room she ran inside and screamed out for help. EMS workers, who were in the hospital, took the child from her, and immediately began CPR and other lifesaving actions. The mother stated that at no time during the transport of the child to the emergency room was the child dropped.

On that same date, law enforcement personnel were interviewed. They reported no overt trauma to the child. The information provided to law enforcement by the mother was consistent with the information provided to ACS. Law enforcement confirmed that the child died 12:51AM on 9/14/20.

Contact with the ME on 9/14/20 revealed the child did not have any broken clavicle bones, bruising, or hematomas to the head or about the body. According to the ME the only injuries observed were broken ribs which was consistent with medical personnel performing CPR on the child. Examination of the child's body showed the child was "structurally fine" and there were no concerns or suspicions that the child was physically being abused; the cause of death was pending

further test.

On 9/15/20, ACS staff filed an Article 10 Petition of Neglect in the Kings County Family Court. The judge granted a 1022 Hearing and the session was adjourned to 9/17/20 at 9:00 AM, to allow ACS to gather additional information as there was inconsistent information provided.

On 9/16/20, ACS staff contacted medical personnel and conducted a case conference with them. It was reported that based on their assessment, there was no finding of abuse or trauma. The doctors expressed that after reviewing the child's x-rays, there were no fractures found on the child. The child had no injuries, no hematoma, and no swelling to his head or brain.

On 9/16/20, ACS's Family Court Legal Services (FCLS) withdrew the petition by the agency based on the information obtained from medical and law enforcement personnel. The surviving children were returned to the care of the mother. ACS ordered beds for the children and they were delivered on 10/1/20. According to ACS, the mother reported that her family would cover the cost for the child's burial.

A post Initial Child Safety Conference was held on 09/16/20 for the family to engage in PPRS services to address family and bereavement counseling, and any other services that the family needs, including early intervention services for the two-year-old child. CPS referred the family for PPRS on 9/25/20. A joint home visit was completed on 10/7/20 with NY Foundling and the mother declined services.

On 9/17/20, ACS staff met with law enforcement who reported they were closing their criminal investigation as no criminality was found.

On 10/1/20 and again on 10/13/20, ACS contacted the children's pediatrician. The pediatrician noted the children were last seen on 9/23/20 and they were fine. Their immunizations were current.

On 10/22/20, school personnel noted there were no concerns with the children's schooling.

Between 9/17/20 and 11/6/20, ACS made several visits to the family home and continued to assess the safety of the surviving siblings. The children were assessed as being safe in the home. The safety assessments completed accurately reflected the circumstances of the case.

On 11/12/20, ACS unsubstantiated the allegations of DOA/Fatality, Swelling, Dislocation, Sprains, Fractures and Inadequate Guardianship of the child by the mother based on no credible evidence found to substantiate the allegations. To support the decision, ACS cited the preliminary report from the ME and other medical personnel, which stated the child had no marks, bruises, and there was no indication of abuse or maltreatment.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056454 - Deceased Child, Male, 3 Month(s)	056422 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
056454 - Deceased Child, Male, 3 Month(s)	056422 - Mother, Female, 29 Year(s)	Fractures	Unsubstantiated
056454 - Deceased Child, Male, 3 Month(s)	056422 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
056454 - Deceased Child, Male, 3 Month(s)	056422 - Mother, Female, 29 Year(s)	Swelling / Dislocations / Sprains	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:
Case documentation did not reflect if a death scene investigation was done.

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?	☐	☐	☒	☐
Explain: Although there were no safety factors that presented an immediate or impending danger to the child(ren), the Specialist recorded safety decision #4 and conducted an emergency removal. ACS later returned the children tot he parent, withdrew the petition, and completed a safety modification that accurately reflected the case circumstances.				

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: During the course of the investigation sufficient information was gathered to assess risk to all surviving children in the household. It was determined the children could benefit from counseling and the 22-month-old child could benefit from Early Intervention services.				

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:
ACS determined the children were in impending or immediate danger of serious harm and completed a removal on 9/15/20. Later that day the children were medically cleared and returned to the mother.

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:**
09/15/2020	There was not a fact finding	Widthdrawn
Respondent:	056422 Mother Female 29 Year(s)	
Comments:	On 9/15/20 ACS filed an Article 10 Petition of Neglect in the Brooklyn Family Court. A 1022 hearing was convened on the same day. The case was adjourned until 9/17/20. However, on 9/16/20, ACS withdrew the petition at the agency's request.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☒	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☒	☐	☐	☐	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☒	☐	☐	☐	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐

Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The surviving siblings were referred for grief and family counseling. Early intervention services were explored for the 22-month-old sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were referred for grief and family counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/11/2017	Sibling, Female, 6 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Substantiated	No
	Sibling, Female, 6 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	

Sibling, Female, 3 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 3 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 1 Years	Mother, Female, 26 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated

Report Summary:
The SCR report alleged for an unknown length of time, the mother had a stroller next to the front door creating a fire hazard for the six-year-old, three-year-old, and one-year-old children. The report also alleged the mother was a hoarder and had piles of clothing and toys throughout the home thus creating unclear paths for the children. The report alleged the mother did not adequately address the issue. The allegations of the report were Inadequate Food, Clothing, Shelter, and Inadequate Guardianship of the children by the mother who was named as the subject of the report.

Report Determination: Indicated | **Date of Determination:** 11/11/2017

Basis for Determination:
ACS substantiated the allegations of the report based on the conditions noted at the time of home visits. The home was observed to be in the condition outlined in the intake report and no efforts were being made to rectify the situation.

OCFS Review Results:
ACS initiated in a timely manner, notified the family of the existence of the report, and made the appropriate collateral contacts. During the course of the investigation, the Specialist incorporated the information obtained in their assessment of the family's functioning. The safety assessments were appropriate. The family obtained more permanent housing and left the homeless shelter in which they were residing. Subsequent visits to the new home saw an improvement in the cleanliness of the home. The family was also notified of the indication of the report.

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

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

The family first came to the attention of the SCR and ACS on 3/12/13 with concerns related to marks and bruises on the then 2-year-old child. The report was investigated and subsequently unfounded on 4/30/13.

Another report was registered on 5/5/15 alleging Inadequate Food, Clothing, Shelter, and Inadequate Guardianship of the mother's two eldest children. The mother had been residing in a homeless shelter at the time of the report. ACS investigated the report and unsubstantiated the allegations for lack of credible evidence. The mother refused services at the time the investigation was closed but later that same year she sought services including housing and legal assistance, as well as early intervention assistance for the then 10-month-old child.

In 2016, three reports were registered regarding unsanitary conditions in the home. ACS investigated the reports and unsubstantiated the allegations for reports received in June and August. ACS documented the mother was providing appropriate care for the children. For the report received in November of that year, ACS indicated the report on the basis of the condition of the home noted during home visits.

Known CPS History Outside of NYS

There is no known CPS History outside of NYS.

Preventive Services History

A Family Services Stage (FSS) was opened on 9/2/16. The family was in receipt of preventive services to address the living conditions in the home. The mother was not fully engaged in the family counseling services for which she was referred and refused to attend parenting skills training. Case notes reflected the mother(family) made minimal progress in keeping their home clean. The mother also did not attend the clinical sessions. Despite her resistance to services, no safety concerns were noted and according to the case notes, the children appeared well and had adequate supervision. On 2/18/18, the preventive services case was closed due to the mother's inconsistency with services and failure to attend appointments.

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