NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-095 **Prepared by: New York City Regional Office**

Issue Date: 5/3/2016

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

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 11/30/2015
Initial Date OCFS Notified: 11/30/2015

Presenting Information

The 11/30/15 report alleged that the mother brought her 2-month-old infant into the hospital after finding the infant unresponsive and discolored. The infant was otherwise healthy and the cause of death was unknown. The medical efforts at the hospital to resuscitate the infant were ineffective.

The 12/1/15 report alleged that on 11/30/15, the infant was found deceased in the home by the mother at approximately 1:45 AM. The infant had bruises to his waist at the time of his death. It was unclear how the infant sustained these injuries. The cause of death was unknown, but the infant was otherwise healthy and did not have any preexisting medical conditions. The mother and MGM were in the home and were caring for the infant at the time of his death. The mother and MGM took the infant to the hospital by cab, but he was dead before his arrival. The report alleged that the mother was impaired by marijuana. The MGM had a history of abusing alcohol while caring for the infant and 3-year-old.

Executive Summary

The 2-month-old male child died on 11/30/15. The autopsy listed the cause and manner of death as Undetermined.

The allegations of the 11/30/15 report were DOA/Fatality and IG of the infant by the mother. A subsequent report was registered on 12/1/15 and the allegations were IG, DOA/Fatality, L/B/W, and PD/AM of the infant by the mother and MGM, and IG of the 3-year-old maternal cousin (MC) by the MGM. ACS added to the report the allegation of PD/AM of the 3-year-old by the MGM.

The ACS investigation revealed that on 11/29/15 at about 11:30 p.m. the mother breast fed the infant and fell asleep with the infant on her chest. She awoke,tried to burp him, and then laid the infant down on his side in the crib. There was a pillow at his back and another pillow in the crib. After about 30 minutes she awoke, checked the infant, and saw his mouth was purple. The infant was still on his side but his face was "turned down a little bit." There was also a small amount of blood coming from his nose. The mother picked up the infant and asked the MGM to call 911.The mother stated they could not find the house phone so the MGM knocked on the neighbors' doors then went upstairs to her sister’s home and called 911. While the MGM was upstairs, she (the mother) walked to the hospital with the infant in her arms. Documentation did not reflect that a confirmation was made regarding the 911 call.

At the hospital, efforts to resuscitate the infant were futile and the infant was pronounced dead.

According to the attending Dr., on 11/30/15 at about 2:09 a.m. the mother walked into the ER holding the infant. She gave the infant to a nurse and efforts were made to resuscitate the infant. The mother told hospital staff that she breast fed the infant and put him to sleep and when she awoke from her nap, she found the infant unresponsive and his face was discolored.

The MA (not the mother of the 3-year-old) who was listed as an other person named on the 12/1/15 report and the hospital physician were not interviewed by ACS. Also, the household composition for the 11/30/15 report was not

reflected in the Principal Information of the CPS Investigation Summary of the 12/1/15 report. ACS did not provide the Notice of Existence to the MGM for the 11/30/15 report. Additionally, other persons named in the 12/1/15 report were not notified of the indication.

On 2/4/16, ACS substantiated the allegation of IG of the 11/30/15 report. ACS determined that the mother failed to exercise the minimum degree of care when she placed the infant in a crib lying on his side with other objects (pillows) in the crib. ACS determined that the mother had received safe sleep training but placed the infant at risk of harm and/or serious injury by creating a dangerous environment for the infant.

ACS unsubstantiated the allegation of DOA/Fatality. ACS documented that no "criminal evidence" was found and there were no signs that the infant was abused. ACS' decision to unsubstantiate the allegation of DOA/Fatality on the standard of "no criminal evidence", was inappropriate as ACS did not use the appropriate criteria for determining whether to substantiate or unsubstantiate an allegation of abuse or maltreatment. The applicable standard is whether there is some credible evidence of abuse or maltreatment as those terms are defined in the Social Services Law and the Family Court Act.

ACS substantiated the allegation of IG of the infant by the mother for the 12/1/15 report. ACS unsubstantiated all other allegations of the 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

Explain:

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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:

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Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The MA (not the mother of the 3-year-old) who was listed as other person named on the 12/1/15 report and the hospital physician of the 11/30/15 report was not interviewed by ACS.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Adequacy of case recording
Summary:	ACS did not update the CONNECTIONS household composition to include all the individuals identified in the Investigation Progress Notes of the 11/30/15 report for this information did not reflect in CPS Investigation Summary of the 12/1/15 report.
Legal Reference:	18 NYCRR 428.5(c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Failure to provide notice of report
Summary:	The Event List did not reflect ACS provided the Notice of Existence to the MGM for the 11/30/15 report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Failure to Provide Notice of Indication
Summary:	The Event List reflected only the mother was provided the Notice of Indication, the other persons named such as the MGM and two MA's were not provided with one.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	ACS inappropriately unsubstantiated the allegation of DOA/Fatality as ACS did not use the appropriate criteria for determining whether to substantiate or unsubstantiated an allegation of abuse

	or maltreatment. The standard is some credible evidence.
Legal Reference:	SSL 412(1) and 412(2)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/30/2015 **Time of Death:** 02:42 AM

Time of fatal incident, if different than time of death: 01:45 AM

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

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	59 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Other Child	Alleged Victim	Female	3 Year(s)

Other Household 1	Father	No Role	Male	19 Year(s)

LDSS Response

Following the receipt of the SCR report, ACS contacted LE and learned there was a blanket and a pillow in the crib in which the infant had been sleeping. ACS learned from the mother that she fell asleep while the infant was still on her chest. She awoke and put the infant in his crib to sleep. There were pillows in the crib. The mother said she normally placed him on his side to sleep in the crib. About 30 minutes later she checked the infant and saw that the infant "seemed different" as his mouth was purple. The infant was still on his side but his face was turned down a little bit.The mother said she called the MGM and when she (the mother) picked up the infant, the infant was not breathing. The mother said she tried CPR and blood came from his nose and he gurgled. The mother also said she asked the MGM to call 911 but walked to the hospital because she could not find the home phone and her cellular phone was not working. The mother said the infant was healthy and everything was fine. The mother learned about safe sleeping arrangements and positions for infants when she was in the hospital after giving birth. Documentation reflected that during the Family Team Meeting, ACS asked the mother why she placed the infant on his side with a pillow to his back if she received safe sleep information. The mother did not provide a definitive answer as to the reason she placed him on his side to sleep. The father said he was not in the home at the time of the incident.

On 12/1/15, the family declined bereavement counseling. The parents admitted to a history of marijuana use. The father admitted he attended an outpatient program.

ACS interviewed the MA and the 3-year-old child. The MA said that she was unsure of what happened to the infant as she was only privy to the account provided to her by her family. The MGM informed ACS that she did not drink alcohol.

The ME said the infant did not have any injuries. The infant was found face up in the crib and unresponsive. He was well hydrated and nourished.

On 12/3/15, ACS received drug tests results for the infant’s parents; they were negative.

On 12/22/15, Nassau County CPS accepted secondary responsibility to do a home assessment of the father’s home. Later, NCCPS visited the father’s home but he was not home. The PGM was interviewed and she said the infant slept in the crib with no items inside of it. Grief counseling was discussed and referrals offered but the PGM declined.

ACS received documentation from the infant’s Dr.’s office regarding a visit which was made five days prior to the infant’s death. The assessment showed the infant had a medical condition. The plan noted instructions for the infant’s care.

On 12/29/15, the mother informed ACS that she had followed the Dr.’s instructions for the infant’s care.

On 2/4/16, ACS substantiated the allegation of IG of the 11/30/15 report. ACS determined that the mother failed to exercise the minimum degree of care when she placed the infant in a crib lying on his side with other objects (pillows) in the crib. ACS determined that the mother had received safe sleep training but placed the infant at risk of harm and/or serious injury by creating a dangerous environment for the infant.

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Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

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
026601 - Deceased Child, Male, 2 Mons	026602 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
026601 - Deceased Child, Male, 2 Mons	026602 - Mother, Female, 19 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
026601 - Deceased Child, Male, 2 Mons	026604 - Grandparent, Female, 59 Year(s)	Inadequate Guardianship	Unsubstantiated
026601 - Deceased Child, Male, 2 Mons	026602 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated
026601 - Deceased Child, Male, 2 Mons	026604 - Grandparent, Female, 59 Year(s)	DOA / Fatality	Unsubstantiated
026601 - Deceased Child, Male, 2 Mons	026604 - Grandparent, Female, 59 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
026601 - Deceased Child, Male, 2 Mons	026602 - Mother, Female, 19 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
026601 - Deceased Child, Male, 2 Mons	026604 - Grandparent, Female, 59 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
026605 - Other Child - cousin, Female, 3 Year(s)	026604 - Grandparent, Female, 59 Year(s)	Inadequate Guardianship	Unsubstantiated

026605 - Other Child - cousin, Female, 3 Year(s)	026604 - Grandparent, Female, 59 Year(s)	Parents Drug / Alcohol Misuse	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The emergency contact number 911 was not called; the mother walked to the hospital with the infant. The MA who was listed on the 12/1/15 report as other person named and a hospital Dr. were not interviewed by ACS.

Fatality Safety Assessment Activities

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

Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity

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	Needed but not Offered	Needed but Unavaliable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☒	☐	☐	☐	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The mother sought therapy at Child Center of NY Flushing Clinic. The parents were referred for a drug test; the results were negative.

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 family declined bereavement counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family accepted burial assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? 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? Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/25/2012	8413 - Mother, Female, 16 Years	8412 - Grandparent, Female, 56 Years	Educational Neglect	Unfounded	Yes

Report Summary:
The 10/25/12 report alleged that the then 16-year-old child was repeating the 8th grade due to poor attendance. The child missed school for the month of September because she was in a foreign country. In October, the child was absent or late every other day. The child was behind academically as a result. The mother was aware and unable to ensure that the child attend school.

Determination: Unfounded | **Date of Determination:** 12/14/2012

Basis for Determination:
ACS based the determination on findings which showed the child was truant from school. The mother had and continued to wake the child for school in the morning, but left for work before the child left for school. The child either took a long time to get ready for school and was extremely late, or she returned to bed after the mother left and did not attend school, causing her to fail her classes. The mother was involved and proactive in reaching out to the school for help with the child. The child received counseling with the Child Center of NY and would continue to receive services.

OCFS Review Results:

The investigation began in a timely manner. The Investigation Progress Notes did not reflect that they were entered within the required 30-day timeframe. There were events that occurred in early November 2012 but were not entered until the middle of December 2012. ACS did not update the CONNECTIONS household composition to include all the individuals identified in the Investigation Progress Notes. The Event List reflected that the Notice of Existence was provided to the subject of the report. Significant collaterals were interviewed such as the child's school and the Child Center of NY that the family had an open Advocates Preventive Only case.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
The Investigation Progress Notes did not reflect that they were entered within the 30-day timeframe as there were events that occurred in early November 2012 but were not entered until the middle of December 2012.

Legal Reference:
18 NYCRR 428.5(a) and (c)

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

Issue:
Adequacy of case recording

Summary:
ACS did not update the CONNECTIONS household composition to include all the individuals identified in the Investigation Progress Notes.

Legal Reference:
18 NYCRR 428.5(c)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/15/2013	8427 - Mother, Female, 17 Years	8426 - Grandparent, Female, 57 Years	Lack of Supervision	Unfounded	Yes
	8427 - Mother, Female, 17 Years	8426 - Grandparent, Female, 57 Years	Childs Drug / Alcohol Use	Unfounded	
	8427 - Mother, Female, 17 Years	8426 - Grandparent, Female, 57 Years	Inadequate Guardianship	Unfounded	
	8427 - Mother, Female, 17 Years	8426 - Grandparent, Female, 57 Years	Lack of Medical Care	Unfounded	

Report Summary:
The 8/15/13 report alleged that the then 17-year-old child abused marijuana, was not compliant with her substance abuse program, and had not been clinically evaluated as required. The child was out of control and the mother was not able to manage the child. The child was out in the streets for three to four days at a time and the mother had no idea of her

whereabouts. There were verbal disputes between the mother and the child and on 8/14/13, the child assaulted the mother. The mother was aware of the situation and failed to follow up on behalf of the child. The situation was getting worse.

Determination: Unfounded	**Date of Determination:** 10/09/2013

Basis for Determination:
ACS based the determination on lack of evidence to prove the mother was neglectful. The mother had been asking Child Center of NY (CCNY) for help for the child, she reported the child missing to LE every time she stayed out for more than 24 hours, she went to Queens Family Court to seek a Person In Need of Supervision (PINS) on the child and often tried to obtain as much information about the child's whereabouts. The child had been very difficult, did not follow through with any of her services, and had not been going to school. The PPRS had been involved for over five years and had not been able to control her behavior.

OCFS Review Results:
The investigation began in a timely manner. ACS documentation of the Investigation Progress Notes reflected that they were entered contemporaneously. During the investigation, on 9/5/13, the Specialist explained to the child if she continued with her behavior which was coming home all hours, starting fights in the home, and physically abusing everyone then there are reasons for ACS to be concerned about the 1 year-old child (now deceased child's cousin). The 1 year-old child's mother could have gone to court and obtain a limited order of protection (OOP) against her. Provided that an OOP was discussed, ACS should have explored a legal consultation with FCLS.

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

Issue:
Assessment as to need for Family Court Action

Summary:
During the investigation, a limited OOP in the same home was discussed. Regarding this discussion, ACS should have conducted a legal consultation with FCLS.

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

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

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

The mother was not known to the SCR or ACS as a subject. The maternal grandmother (MGM) was known to the SCR and ACS in two reports dated 11/29/07 and 6/24/11. The allegations of the 11/29/07 report were IG and L/B/W. The allegations were unsubstantiated. The allegations of the 6/24/11 report were IG, LS, and EdN. The allegations were unsubstantiated.

On 11/17/15, a Family Service Stage (FSS) was opened for a court ordered investigation (COI). ACS was ordered by the Queens Family Court to conduct a COI as the MGM petitioned the court for guardianship of the 3-year-old child. On 11/18/15, ACS conducted a visit to the home. The MGM was interviewed and the 3-year-old child was observed wearing a pamper. The MGM explained that the 3-year-old still wore pampers but was potty trained. According to the MGM, the child asked to wear the pampers when they go out because she did not like pubic restrooms. A crib was observed. The MGM said that she had a daughter (mother of the deceased infant) who visited and had an infant. The MGM said she

watched the infant once in a while and had the crib in case the infant visited. ACS discussed safe sleep practices with the MGM. The MGM said she was aware of safe sleep. The MGM reported that she asked the 3-year-old child's mother to leave the child with her instead of having her live from place to place.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

On 12/12/08, the case was opened in the Family Service Stage (FSS). The family was referred by the MA's school guidance counselor on 11/12/08 as the MA engaged in high risk and defiant behaviors, and was socializing with older negative peers. The MGM signed for services on 12/11/08 with the Child Center of New York (CCNY). CCNY serviced the family from 12/11/08 to 4/9/14 until all three children reached their 18th birthday. Service Termination conferences were held on 12/22/10, 6/1/11, and 11/16/11. However, the children's behavior decompensated after each conference imposing further interventions from CCNY.

CCNY provided the following preventive services continuously throughout the life of the case: referrals for outpatient clinical health counseling, clinical evaluations, substance abuse outpatient program, Single Stop program, conducted school visits, and Individual Education Program (IEP) school conferences, and other conferences. CCNY also conducted home visits, and provided family sessions/conflict resolution, assisted the MGM with filing missing person reports for children, risk and safety assessments of all the children, and monitored the MGM's compliance with medical/clinical health treatments. CCNY also completed Referral for Child Care and Head Start, and Babby Buggy when the MA had the 3-year old.

Required Action(s)

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

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child’s siblings, and/or the other children residing in the deceased child’s household at the time of the fatality.

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: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The MGM petitioned the Queens Family Court for guardianship of the 3 year-old child.	

Have any Orders of Protection been issued? Yes	
From: 01/07/2014	**To:** 02/10/2015
Explain: On 1/7/14, the maternal aunt was issued a temporary order of protection from Queens County Court against the mother. The order of protection expired on 2/10/15.	

Recommended Action(s)

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

Action:	Documentation reflected that on 11/17/15, a COI was ordered by the Queens Family Court as the MGM filed for guardianship of her 3-year-old grandchild. The COI was not registered through the SCR. ACS should upon further exploration of a COI assess if information obtained necessitated the registration of a child abuse/neglect report with the SCR.

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