Child Fatality Report

Report Identification Number: NY-17-009

Prepared by: New York City Regional Office

Issue Date: Aug 14, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Richmond
Gender: Male
Date of Death: 07/24/2014
Initial Date OCFS Notified: 01/26/2017

Presenting Information

The 1/26/17 report alleged that on 7/24/14, during dismissal the daycare provider, who was the only known sole caregiver at the time, failed to supervise the 3-year-old child who wandered off alone to a family pool located in the backyard. As a result, the child slipped and fell into the pool and drowned. The date of death was 7/24/14.

The report also alleged that the daycare provider and her daughter, both daycare providers, smoked marijuana and drank alcohol while caring for multiple children in the current daycare. The unknown maltreated represented these multiple children. As a result of the drug and alcohol misuse, the two daycare providers engaged in verbal disputes and physical violence in the presence of the children. It was unknown if any of these unknown children suffered any injuries as a result.

Executive Summary

The 3-year-old male child (SC) died on 7/24/14. The autopsy listed the cause of death as drowning and the manner of death was an accident.

The allegations of the 1/26/17 report were DOA/Fatality and LS of the SC by the daycare provider (DCP) and IG and PD/AM of an Unknown child by the DCP and another provider referred to as DCP1. The SC's death was previously investigated by ACS during the 7/24/14 and 7/25/14 investigations. OCFS completed and issued fatality report NY-14-085 pertaining to the ACS investigation of the deceased SC.

The NYC Department of Health (DOH) said the case had been coded incorrectly by the SCR. DOH added that the case was coded as Inappropriate Behavior. The fatality was investigated in 2014 and the DC was closed, and the provider license was revoked. The DC at the current location was owned and operated by the DCP. The on-site provider's name was provided to ACS. There were two assistants; one was the DCP1. The DCP1 was a pending assistant and at this time, she could be in the facility, but should not conduct activities regarding caring for the children. She still had to be cleared to have access to the children. ACS inquired the issue of the DCP being allowed to open and operate the DC after her original DC was closed. DOH said that legally they could not stop her from opening another business.

The documentation did not reflect that the SC's mother was interviewed despite being named in the 1/26/17 fatality report. The Investigation Progress Notes was not entered contemporaneously as there were notes that were entered on 3/25/17; for event that occurred on 1/27/17. On 1/27/17, ACS documented inaccurate information pertaining to the SCR history as the report dated 7/18/11 was IND against the MGM for IG; however, the allegation was Unsub against her although the report was IND against two other subjects.

On 3/27/17, ACS Unsub the allegations of DOA/Fatality and LS of the SC by the DCP and Unsub the allegations of IG and PD/AM by the DCP and DCP1 of an Unknown child on the basis of a lack of credible evidence. The allegations of DOA/Fatality and LS were previously investigated by ACS in 2014 and at that time the allegations were Sub due to credible evidence. However, the substantiated case against the DCP was later overturned through an Administrative Review. The DCP and DCP1 submitted to a drug test, and the test was negative for all substances. There were no other concerns regarding any children that the DCP had cared for per the biological parents of the four children. DCP1 was not assisting with any children in the existing DC.

The SCR registered four reports dated 1/26/17, 1/27/17, 3/1/17 and 3/6/17. The allegations of the 1/26/17 report were IG of the 15-year-old child by the parents, three adult siblings, and an unrelated home member (UHM), and PD/AM by the UHM, SM(DCP), and sibling (DCP1). On 3/20/17, ACS Unsub the allegations. However, the Allegation Information listed five, not six subjects and the CPS Principal Information reflected that the 17-year-old child was a subject of the report.

The allegations of the 1/27/17 report were IG of a 14-year-old and 15-year-old female foster children by the FF, FM (DCP) and four UHM's (one was DCP1), and PD/AM by the FF, FM, and two UHM's. The CPS Principal Information again reflected that the 17-year-old child was a subject of the report. On 3/20/17, ACS Unsub the allegations.

The allegations of the 3/1/17 report were IG and PD/AM by a mother of a 4-year-old female child and 9-year-old female child. ACS added the DCP1(who was listed as a Parent Substitute) as a subject with the allegation of IG. On 4/20/17, ACS Unsub the allegations.

The allegations of the 3/6/17 report were IG of the 9-year-old, 12-year-old and 4-year-old female children by the sibling and PS (DCP1). On 4/5/17, ACS Unsub the allegations.

The documentation reflected that the DCP was previously a foster parent, but her foster home was closed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The documentation was not entered contemporaneously as there were notes that were entered on 3/25/17 for an event that occurred on 1/27/17.
Legal Reference:	18 NYCRR 428.5(a) and (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:	Face-to-Face Interview (Subject/Family)
Summary:	The documentation did not reflect that the SC's mother was interviewed.
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 case recording
Summary:	On 1/27/17, ACS documented inaccurate information pertaining to CPS history as the investigation dated 7/18/11 was IND against the MGM for IG; however, the allegation was UNF against her although the report was IND against two other subjects.
Legal Reference:	18 NYCRR 428.5(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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/24/2014 **Time of Death:** 06:20 PM

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

County where fatality incident occurred: Richmond
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to 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
- ☒ Playing
- ☐ Working
- ☐ Eating
- ☐ Driving / Vehicle occupant
- ☐ 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
If the child was in day care at the time of the fatality, was the day care program duly licensed or registered? Yes
Licensing/Registering Agency: NYC DOH
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	No Role	Female	23 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	47 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	20 Year(s)
Other Household 2	Other - Multiple Children	Alleged Victim	Unknown	7 Year(s)

LDSS Response

On 1/27/17, a family acquaintance said the DC was shut down after a child drowned in the pool. ACS learned that the DC moved next door to its previous location, and obtained a new license. The DCP was not supposed to be operating a DC and NYS was not aware of the activities. He said there was a fence between the two backyards. The DCP was also a foster parent. The other concern was the family's marijuana and alcohol misuse in the presence of the children during their summer pool parties and DV with DCP1.

On 1/27/17, ACS visited the DC but was unable to gain access. ACS interviewed the DCP in the home of the DCP. The DCP said the report was false. The DCP said she was a licensed DCP since 2010, but the current DC had been licensed for August 2016 through August 2020. The DC was closed by DOH due to violations at another address in 2014, but the current DC was at a new address. The DCP must have a cleared on-site provider as the DCP was not allowed to care for children on her own. The DCP said she was not currently running a DC at the address. She said she cared for one child in the morning but not every day, as the arrangement was based on the mother's schedule. She also cared for three sibling children; on some days, from 2:30 PM to 5:00 PM. She said there were no children attending the DC on a regular basis. The DCP said she planned to speak with the DOH to obtain another onsite provider. The documentation reflected that on 1/27/17, the DCP1 was interviewed by the supervisor at her home, but the details of the interview were not documented.

On 1/31/17, ACS staff visited the DC, and there were no concerns. The supervisor used an exit door in the home that lead to the backyard where the pool was located. There was a high black gate separating the pool from the home.

On 2/1/17, the on-site provider denied she observed the use of drugs/alcohol in the DC or in the DCP's home.

On 2/3/17, ACS obtained drug test results which were negative for the DCP. Later, ACS obtained drug test results which were negative for the DCP1. The ACS case record reflected that the DCP and DCP1 completed a Certified Alcohol and

Substance Abuse Counselor (CASAC) assessment; both did not meet the requirement for intake.

On 3/9/17, ACS visited the DC and spoke with the DCP's mother-in-law who said the DC was no longer in service. The DC was observed and there were no children in attendance.

On 3/21/17, the DCP said she identified an on-site provider. She said she did not have any children enrolled as she was waiting for the on-site provider clearances.

On 3/21/17, the mother of the 2-year-old child enrolled in the DC was interviewed. She said she did not observe the staff at the DC under the influence of any substances. There were no concerns regarding the care her child received from the DCP or any other staff member. She was aware of the incident regarding the SC who drowned in the pool. The mother of the three children ages 10, 9, and 7 said she had no concerns regarding any of the staff at the DC.

On 3/22/17, ACS received information from the DOH. The documentation reflected that on 3/16/17, the DCP received a violation for not having the results of SCR database check on file for pending assistants in that it was returned to the applicant. The DCP also admitted to the inspector that she had been caring for four children enrolled in the program. The assistants and pending on-site provider had not been working due to the low enrollment; no notice was observed on site to parent informing them that the provider was not present.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external 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 investigations.

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
039281 - Deceased Child, Male, 3 Yrs	039285 - Day Care Provider, Female, 47 Year(s)	Lack of Supervision	Unsubstantiated
039281 - Deceased Child, Male, 3 Yrs	039285 - Day Care Provider, Female, 47 Year(s)	DOA / Fatality	Unsubstantiated
039286 - Other - Multiple Children, UNK, 7 Year(s)	039285 - Day Care Provider, Female, 47 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
039286 - Other - Multiple Children, UNK, 7 Year(s)	039284 - Day Care Provider, Female, 20 Year(s)	Inadequate Guardianship	Unsubstantiated
039286 - Other - Multiple Children, UNK, 7 Year(s)	039284 - Day Care Provider, Female, 20 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
039286 - Other - Multiple Children,	039285 - Day Care Provider, Female,	Inadequate	Unsubstantiated

UNK, 7 Year(s)	47 Year(s)	Guardianship	

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:
Documentation did not reflect that the SC's mother was interviewed. The fatality was previously investigated when reports were registered on 7/24/14 and 7/25/14. Notes were entered on 3/25/17, but the event occurred on 1/27/17.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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 documentation reflected that the DCP and DCP1 completed CASAC assessment.

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? No
Explain:
The SC did not have siblings. During the 1/26/17 Fatality investigation, there were no immediate needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The documentation reflected that the DCP and DCP1 completed a Certified Alcohol and Substance Abuse Counselor (CASAC) assessment.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

Was there an open CPS case with this child at the time of death? 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? N/A
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)	Status/Outcome	Compliance Issue(s)
10/14/2015	Other - child, Female, 4 Years	Day Care Provider, Female, 49 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes
	Other - child, Male, 4 Years	Other - Unrelated Home Member, Female, 24 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other - child, Female, 4 Years	Day Care Provider, Female, 49 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other - child, Male, 4 Years	Day Care Provider, Female, 21 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other - child, Male, 4 Years	Day Care Provider, Female, 49 Years	Inadequate Guardianship	Unfounded	
	Other - child, Male, 4 Years	Other - Unrelated Home Member, Female, 24 Years	Inadequate Guardianship	Unfounded	
	Other - child, Female, 4 Years	Other - Unrelated Home Member, Female, 24 Years	Inadequate Guardianship	Unfounded	
	Other - child, Female, 4 Years	Day Care Provider, Female, 21 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other - child, Female, 4 Years	Day Care Provider, Female, 49 Years	Inadequate Guardianship	Unfounded	
	Other - child, Female, 4 Years	Other - Unrelated Home Member, Female, 24 Years	Inadequate Guardianship	Unfounded	
	Other - child, Female, 4 Years	Day Care Provider, Female, 21 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other - child, Female, 4 Years	Other - Unrelated Home Member, Female, 24 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other - child, Female, 4 Years	Day Care Provider, Female, 49 Years	Inadequate Guardianship	Unfounded	
	Other - child, Female, 4 Years	Day Care Provider, Female, 21 Years	Inadequate Guardianship	Unfounded	
	Other - child, Female, 4 Years	Other - Unrelated Home Member, Female, 24 Years	Inadequate Guardianship	Unfounded	
	Other - child, Male, 4 Years	Day Care Provider, Female, 49 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other - child, Female, 4 Years	Day Care Provider, Female, 49 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other - child,	Day Care Provider, Female, 21	Parents Drug /	Unfounded	

Female, 4 Years	Years	Alcohol Misuse	
Other - child, Female, 4 Years	Other - Unrelated Home Member, Female, 24 Years	Parents Drug / Alcohol Misuse	Unfounded
Other - child, Female, 4 Years	Other - Unrelated Home Member, Female, 24 Years	Parents Drug / Alcohol Misuse	Unfounded
Other - child, Female, 4 Years	Day Care Provider, Female, 49 Years	Inadequate Guardianship	Unfounded
Other - child, Male, 4 Years	Day Care Provider, Female, 21 Years	Inadequate Guardianship	Unfounded
Other - child, Female, 4 Years	Day Care Provider, Female, 21 Years	Inadequate Guardianship	Unfounded
Other - child, Female, 4 Years	Day Care Provider, Female, 21 Years	Inadequate Guardianship	Unfounded

Report Summary:
The 10/14/15 report alleged that the daycare providers, DCP and DCP1, drank alcohol while providing care to the four children (1 male, 3 female). While under the influence, daycare providers became physically violent with one another in the presence of the children. DCP1 also became violent with others while in the presence of the children. There was a pool in the back yard which did not have the proper fencing around it.

Determination: Unfounded | **Date of Determination:** 12/10/2015

Basis for Determination:
There was a lack of credible evidence to Sub. the allegations of the report. ACS interviewed several collateral contacts who did not have any complaints about the DC. The daycare providers and unrelated home member (UHM) all denied the allegations. The UHM said she did not work for the DC and she was a friend of DCP1. The UHM and DCP were sent for drug screening and tested negative for drugs and alcohol. The DCP1 was referred for drug screening, but was unable to go.

OCFS Review Results:
The DCP explained she was certified to run a DC but chose not to currently. The DCP had four foster children in her home. The DCP denied the allegations. She denied that the DCP1's friend worked at the DC nor was the friend around the DC children. The DCP1 also denied the allegations. DCP1 said she did not work at the DC she assisted her mother (DCP). She also said her friend did not work at the DC. The NYC Department of Health (DOH) said the DCP daycare was a licensed DC since 2015 and the location was provided. The DC at the previous address was revoked and suspended since May 2015.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
The Investigation Progress Notes were not entered contemporaneously as there were events that occurred on 10/15/15 but were not entered until 11/30/15 and 12/10/15, respectively.

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

Date of	Alleged	Alleged	Allegation(s)	Status/Outcome	Compliance

SCR Report	Victim(s)	Perpetrator(s)			Issue(s)
10/14/2015	Other Child - child of day care provider, Male, 16 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	Yes
	Other Child - child of DCP1 friend, Female, 2 Years	Mother, Female, 49 Years	Inadequate Guardianship	Unfounded	
	Other Child - child of DCP1 friend, Female, 2 Years	Other - Parent Substitute/DCP1, Female, 21 Years	Inadequate Guardianship	Unfounded	
	Other Child - child of DCP1 friend, Female, 2 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	
	Other Child - child of day care provider, Male, 16 Years	Other - Parent Substitute/DCP1, Female, 21 Years	Inadequate Guardianship	Unfounded	
	Other Child - child of day care provider, Male, 16 Years	Mother, Female, 49 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other Child - child of day care provider, Male, 16 Years	Other - Parent Substitute/DCP1, Female, 21 Years	Parents Drug / Alcohol Misuse	Unfounded	
	Other Child - child of day care provider, Male, 16 Years	Mother, Female, 49 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 10/14/15 report alleged that the mother, and sibling drank alcohol while caring for the 16-year-old female child. While under the influence, the adults became physically violent with one another while in the presence of the child.

Determination: Unfounded **Date of Determination:** 12/10/2015

Basis for Determination:
There was a lack of credible evidence to Sub the allegations of the report. ACS interviewed several collateral contacts who did not have any complaints about the DCP (role listed as mother) and DCP1 (role listed as Parent Substitute). The mother of the 2-year-old child, DCP and DCP1 denied the allegations. The mother of the 2-year-old child does not work for the DC and she was a friend of DCP1. The DCP and mother of the 2-year-old were sent for drug screening and tested negative for drugs and alcohol. The DCP1 was referred for drug screening, but was unable to go.

OCFS Review Results:
The DCP1s friend said that she did not drink alcohol in front of the then 16-year-old child. The friend denied she and the DCP1 had a physical altercation. The friend said her child's father was harassing her. The DCP denied that the DCP1 and DCP1s friend have physical altercations. The DCP denied drinking in front of the 16-year-old child and becoming violent or that the friend and DCP1 become drunk in front of him and became violent. DCP1 denied that her friend and the DCP had physical altercations. The 16-year-old child denied that the DCP, DCP1, and the DCP1's friend argue. He did not observe them drink alcohol or observe them engaged in verbal or physical confrontation.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
ACS did not enter the Investigation Progress Notes contemporaneously as their were events that occurred on 10/19/15, but were not entered until 12/1/15.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/25/2014	Deceased Child, Male, 3 Years	Day Care Provider, Female, 47 Years	DOA / Fatality	Unfounded	No
	Deceased Child, Male, 3 Years	Day Care Provider, Female, 20 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 3 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 3 Years	Day Care Provider, Female, 22 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 3 Years	Day Care Provider, Female, 47 Years	Lack of Supervision	Unfounded	
	Deceased Child, Male, 3 Years	Day Care Provider, Female, 47 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 7/25/14 report alleged that on 7/24/14, the SC was left alone in a play area outside of the group family DC. The SC was not being provided with adequate supervision and was able to squeeze through a fence and subsequently drown in a pool located behind the DC.

Determination: Unfounded | **Date of Determination:** 09/04/2014

Basis for Determination:
The SC was not in the direct care of the DC at the time of the incident; however, during the hours the DC was still operating the SC drowned in the pool on the property. The DCP had an installed fence which was 56 inches in height, which was above the required 48 inches. However, by having a bin placed in front of the fence, the SC was in a position to climb the fence, and the required 48 inches was reduced to be below the requirement and this allowed him to gain access to the pool and accidentally drown. Although the SC drowned in the pool on the property of the DC, the SC was in the physical custody of the step-grandfather at the time of his death. The BM worked at the DC.

OCFS Review Results:
Initially, the allegations of IG, LS, and DOA/Fatality by the DCP was Sub by ACS on 9/4/14. On 9/17/14, an Administrative Review was requested. On 11/6/14, the allegations were modified to Unsub, and Amend to legally Seal. OCFS issued Fatality Report NY-14-085 on 1/20/15 pertaining to the SC's death 7/24/14.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/25/2014	Deceased Child, Male, 3 Years	Mother, Female, 23 Years	DOA / Fatality	Unfounded	No
	Deceased Child, Male, 3 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 3 Years	Mother, Female, 23 Years	Lack of Supervision	Unfounded	

Report Summary:
The 7/25/14 report alleged that on 7/24/14, the BM failed to provide the SC with adequate supervision leaving him alone outside in a play area. This occurred at the BM's place of employment. While left unsupervised, the SC was able to squeeze through a fence and subsequently drown in a pool.

Determination: Unfounded | **Date of Determination:** 10/14/2014

Basis for Determination:
There was no credible evidence to Sub. the allegations. Based on all accounts, the BM was not aware the SC had returned to the DC and left unattended in the play area of the DC by a relative. At the time, the BM was still completing her shift as the DC employee. The ME autopsy report listed the cause of death as drowning and the manner as accidental.

OCFS Review Results:
OCFS issued Fatality Report NY-14-085 on 1/20/15 pertaining to the SC's death 7/24/14.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/24/2014	Deceased Child, Male, 3 Years	Father, Male, 29 Years	DOA / Fatality	Unfounded	No
	Deceased Child, Male, 3 Years	Father, Male, 29 Years	Lack of Supervision	Unfounded	
	Deceased Child, Male, 3 Years	Mother, Female, 23 Years	DOA / Fatality	Unfounded	
	Deceased Child, Male, 3 Years	Mother, Female, 23 Years	Lack of Supervision	Unfounded	

Report Summary:
The 7/24/14 report alleged that on 7/24/14, the 3-year-old SC was not adequately supervised by the BM and BF. The SC was found unresponsive by the family's pool. The parents were providing conflicting details regarding the incident. The SC had since passed away.

Determination: Unfounded | **Date of Determination:** 10/14/2014

Basis for Determination:
There was no credible evidence to substantiate. Based on all accounts the BM was not aware the SC had returned to the DC and left unattended in the play area of the DC by a relative. At the time, the BM was still completing her shift as the DC employee. The BF was not present at the DC where the SC drowned. The BF did not have legal custody and had no child caring responsibility of the SC. The ME autopsy listed the cause of death as drowning and the manner as accidental.

OCFS Review Results:
OCFS issued Fatality Report NY-14-085 on 1/20/15 pertaining to the SC's death 7/24/14.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/24/2014	Deceased Child, Male, 3 Years	Grandparent, Male, 45 Years	Lack of Supervision	Indicated	No
	Deceased Child, Male, 3 Years	Grandparent, Male, 45 Years	DOA / Fatality	Indicated	

Report Summary:
The 7/24/14 report alleged that on, 7/24/14, the grandfather left the SC in a gated play area around the side of the house. The SC climbed the gate and went to the pool area. The SC then got on top of a deck box to climb the fence. The SC fell in the pool and drowned. The grandfather was in front of the house listening to the radio when the incident occurred. The grandfather failed to provide adequate supervision for the SC.

Determination: Indicated	**Date of Determination:** 10/14/2014

Basis for Determination:
ACS IND the report due to some credible evidence. Based on the ME autopsy report, the cause of death was drowning and the manner of death was accidental. The step-grandfather failed to provide a minimum degree of care and failed to safeguard a child under the age of four. The SC was unsupervised for a period of time (at least 10 minutes) and the SC was able to gain access to an above-the-ground swimming pool. The SC subsequently drowned and was found floating in the pool by the BM who believed the SC was with the step-grandfather. Based on all accounts the grandfather was legally responsible for the SC. The step-grandfather picked up the SC from DC at about 5:00 PM.

OCFS Review Results:
OCFS issued Fatality Report NY-14-085 on 1/20/15 pertaining to the SC's death 7/24/14.

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

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

Between 4/25/11 and 7/18/11, the SC was known as a confirmed maltreated child in two reports. The allegations of the 4/25/11 report was IG of the SC by the mother. The report was IND. The allegations of the 7/18/11 report were IG and PD/AM of the SC by the mother, IG by the father and MGM. The allegations were Sub against the parents and Unsub against the MGM.

The DCP was known to the SCR and ACS as a parent who was listed as having no role in two reports dated 10/30/06 and 12/3/09. The DCP1 was not known to the SCR or ACS as a subject.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Required Action(s)

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

Preventive Services History

On 6/20/11, a Family service Stage (FSS) was opened. The MGM petitioned the Family Court for custody of the SC, a Court Ordered Investigation (COI) was ordered and it was completed by 7/25/11. Regarding the family functioning, the 9/19/11 FASP reflected, the BM was intoxicated at the time she arrived at the PGM's home with the child. The BF was at home with his paramour. An argument occurred and the BM attempted to stab the BF with a knife. The BM left with the SC. The FSS was closed on 7/7/13 as services were no longer required.

On 8/5/11, ACS filed an Article Ten Neglect Petition listing the parents as the respondents. The Court ordered the SC's temporary release to the BM under ACS supervision upon the following terms: the BM reside with the MGM, enroll and test negative in an alcohol treatment program, enroll and comply with DV services, enforce the temporary order of protection (TOP) against the BF and comply with her own TOP. The case was referred for preventive services on 11/2/11. On 6/21/12, the BM completed alcohol treatment program, anger management, and parenting skills. She also received DV counseling. On 9/24/12, the family was in Court for a custody hearing in which the Court ordered the BM and MGM joint legal custody of the child. The MGM had primary physical custody of the child.

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the provider comply with discipline standards?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:** 01/31/2017	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 01/27/2017	☒	☐	☐	☐
Was a check completed through the Staff Exclusion List? **Date:**	☐	☐	☐	☒

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: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
Unknown	Adjudicated Neglected	Direct Custody Transferred toContinued with Relative (Article 10)
Respondent:	039283 Mother Female 23 Year(s)	
Comments:	The Family Court ordered final order of custody granting the respondent BM and MGM joint legal custody, and the MGM had primary physical custody.	

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