Child Fatality Report

Report Identification Number: NY-17-129

Prepared by: New York City Regional Office

Issue Date: May 18, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 9 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 11/22/2017
Initial Date OCFS Notified: 11/23/2017

Presenting Information

The 11/23/17 report alleged that the SM and SF put the 9-month-old SC to sleep in his crib at 10:00 PM on 11/22/17. At 11:00 PM, the parents returned to the room and found the SC face down in his crib. The SC was not breathing and appeared to be pale. The parents immediately contacted 911. EMS performed CPR at the scene in the ambulance. The SC was then transported to the hospital. The SC was pronounced dead at the hospital at 11:36 PM. This was an otherwise healthy child with no known medical issues. The suspected cause of death was Sudden Infant Death Syndrome.

Executive Summary

The 9-month-old male child (SC) died on 11/22/17. As of 4/20/18, NYCRO had not received the autopsy report.

The allegations of the 11/23/17 report were DOA/Fatality and IG of the SC by the parents. The SC had two siblings who were in foster care with the Little Flower Children Services (LFCS) agency through an Article Ten petition filed on 9/29/16 for XCP and SA; the parents were named as the respondents. Later, the SM gave birth to the SC and ACS filed an Article Ten petition citing derivative neglect of the SC. After a 1027 hearing, the SC was released to the parents with ACS supervision.

ACS learned on 11/22/17, at approximately 9:15 PM, the SF fed the SC. At approximately 10:00 PM, the SF placed the SC on his back in the “crib” (combination/convertible "Pack 'n Play") to sleep. The SF said there were two blankets in the "Pack 'n Play." The SF cooked and cleaned in the kitchen and at about 10:30 PM, the SM went to the room and observed the SC lying on his side. The SF said the SM checked the SC a second time at about 11:00 PM and saw the SC was face down with his face on the blanket. The SF picked up the SC who made what appeared to be a “squeaky breathing sound.” He then began chest compressions. He said the SM went to the neighbors to call 911. The SF reported the SC had no medical concerns, but took prescribed medication as the SC had a cold. The parents' bedroom was observed to have a bed and next to it a "Pack 'n Play" (described as a playpen). There were two comforters (ACS referred to as blankets) inside it. The SF said the first comforter was placed underneath the SC; the second one was used to cover the SC.

On 11/27/17, the foster care CP said that on 3/20/17, the SF was referred to sex offender and parenting skills classes. Although the referral was initially made, it was resubmitted for the SF due to limited class availability. The services were later transferred to a Dr. On 8/14/17, the intake was completed and the SF began services at the facility. The SM was referred to anger management and parenting skills classes. Later, the CP reported the parents engaged in bereavement counseling. The SSs began to receive tutoring in the parents' primary language.

On 11/29/17, the ME reported the SC had no injuries or trauma, and there was no concern about abuse. The ME said the SC seemed to have received adequate care. ACS shared inconsistencies provided by the parents. The ME said that this could be a result of the limited English proficiency issues. Later, the ME stated the preliminary cause of death was listed as a pre-existing medical condition. The ME reported the parents were not responsible for the SC’s death.

The 24-Hour and Seven-Day safety assessments were completed in a timely manner; respectively on 11/24/17 and 11/30/17. The 11/24/17 safety assessment was inadequate as one of the comments that was documented to support the selected safety factor pertained to the SC and should have focused on observations of the SSs. The 11/30/17 and 12/27/17 safety assessments were inadequate as comments that were documented to support the selected safety factor pertained to

the SC, not the SSs. The documentation did not reflect that ACS interviewed the SC's family members.

On 1/30/18, ACS Unsub the allegation of DOA/Fatality of the SC by the parents. ACS based the determination on the ME's preliminary findings that the SC died due to a medical condition.

ACS Sub the allegation of IG because despite being educated about safe sleep, the parents placed the SC in his "Pack 'n Play" unattended without a mattress. The parents had refused to accept a crib for the SC. A blanket was placed for the SC to lay and another blanket was placed on top of the SC to cover him as he slept despite being made aware of the hazards of doing such.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Was the decision to close the case appropriate? N/A

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

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

Explain:
NA

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 11/24/17 safety assessment was inadequate as one of the comments that was documented to support the selected safety factor pertained to the SC and did not include information about the SSs.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)

Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 11/30/17 Seven-Day safety assessment was inadequate as comments that were documented to support the selected safety factor pertained to the SC and did not include information about the surviving siblings.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The 12/27/17 safety assessment was inadequate as a comment that was documented to support the selected safety factor pertained to the SC and did not include information about the surviving siblings.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The documentation of the fatality investigation did not reflect that ACS interviewed the SC's family members.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/22/2017 **Time of Death:** 11:36 PM

Time of fatal incident, if different than time of death: 11:00 PM

County where fatality incident occurred: Kings

Was 911 or local emergency number called? Yes

Time of Call: 11:04 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
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	9 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Other Household 1	Sibling	No Role	Female	11 Year(s)
Other Household 1	Sibling	No Role	Male	3 Year(s)

LDSS Response

Following the receipt of the SCR report, on 11/23/17, ACS interviewed the attending Dr. about the fatality. ACS learned that the SC was placed in a bed on his back. The family was in the kitchen and when they checked the SC he was face down in the crib. ACS verified that the SF walked out of the home with the SC in his arms when EMS arrived at the scene.

On 11/23/17, ACS visited the foster home, assessed the two SSs and noted that these CHN seemed healthy.
ACS visited the parents' home twice to interview the SM and SF. During the first interview, the SM seemed withdrawn as she did not speak with ACS; the SF participated in the interview. During the second visit, the SF showed the "Pack 'n Play" in which there were two medium-sized blankets. The SF said he fed and put the SC to bed at 9:00 PM. The SM later entered the room and found the SC in a face down position. He stated the SM called 911 but asked the neighbor for help due to limited English proficiency. The SM requested assistance in obtaining a burial site and ACS appropriately provided the referrals.

On 11/24/17, the parents were interviewed to clarify the timeframes concerning the care the infant received just prior to the time he was found in the face down position. The SM said that at 9:30 PM, the SF placed the SC on his back in his "Pack 'n Play" and waited 30 minutes until he fell asleep. SM said the SF left the lights on and the door open. After the SF left the room, he ate and went inside his room. The SM said she checked the SC at 10:00 PM and 10:30 PM and did not observe any concerns. The SM returned at 11:00 PM and at that time she became concerned as she saw the SC was turned over on his stomach with his face pressed against the bed sheets. The SC was not breathing, his face was discolored, his lips were blue and his body was still. The SM called the SF into the room and he started CPR. The SM tried to call 911

twice at 11:00 PM and 11:01 PM, but was unable to proceed due to limited English proficiency and therefore she obtained the neighbor's assistance. SM said the neighbor's child's nurse called 911. She said the SF laid the SC in the middle of the "Pack 'n Play" on his back. There were two blankets, one for the SC to lay on and the other to cover him for warmth. The SF's account and explanation was similar to the SM's. The SF acknowledged that the SM brought the SC to his room and he also observed the SC's lips were blue and his face was discolored.

ACS addressed the issue of safe sleep practices with the parents. The SM said she did not recall much about safe sleep issues and was never educated about safe sleep practices. The SF recalled the hospital provided him and the SM with a video which was in a foreign language and the caseworker provided a pamphlet in English, but did not explain safe sleep practices to them. The SF acknowledged he was aware that CHN were not supposed to sleep on the same bed with adults. He said he folded one blanket and placed the SC on top of the blanket with no covers. ACS documentation of the SF's and SM's interview on 11/24/17 did not reflect whether this was normal practice or what position they usually placed the SC to sleep.

On 12/4/17, the service provider informed ACS about the current service plan. The last time the SM came to the office for a session was on 9/7/17 and the SF had not been in since 11/22/17. The service provider said the SM stated she no longer needed services since she completed the service plan mandated by the Family Court, and was no longer interested in engaging in services at the office. The service provider had not been in contact with the parents since the death of the SC.

On 12/26/17, LE said an arrest had not been made as the results of the autopsy were pending.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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
044701 - Deceased Child, Male, 9 Mons	044702 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated
044701 - Deceased Child, Male, 9 Mons	044703 - Father, Male, 50 Year(s)	DOA / Fatality	Unsubstantiated
044701 - Deceased Child, Male, 9 Mons	044702 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
044701 - Deceased Child, Male, 9 Mons	044703 - Father, Male, 50 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
School	☐	☒	☐	☐
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 documentation did not reflect whether ACS interviewed the SC's family members or the 11-yo-old CH's school.

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 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:
The family had an active case in Kings County Family Court at the time of the fatality. The Article Ten petition was filed on 9/29/16 for XCP and SA; the parents were named as the respondents. The SM physically assaulted the 11-yo-CH by hitting her excessively in the back of the neck and pinching the CH on her thighs leaving red welts and bruises. The two CHN were remanded to foster care.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: 01/03/2018	**To:** Unknown

Explain:
A final limited OP against the SM for the two CHN.

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
The 11-yo and 3-yo CHN remained in foster care. During the 3/16/17 investigation, the foster care agency stated that the SM completed parenting classes; the SF missed two sessions. The documentation did not reflect the parents were offered burial assistance by ACS.

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 two SSs were in foster care at the time of SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The CP reported the parents engaged in bereavement counseling.

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?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	Yes
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)
03/16/2017	Deceased Child, Male, 24 Days	Mother, Female, 35 Years	Inadequate Guardianship	Indicated	No
	Deceased Child, Male, 24 Days	Father, Male, 49 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 3/16/17 SCR report alleged that the SM gave birth to the infant (SC). The report also alleged the SM had two previous CHN removed from her care. The SM's behavior had placed the newborn at risk.

Determination: Indicated | **Date of Determination:** 04/10/2017

Basis for Determination:
The physical, emotional, and clinical condition of the SC had been put in danger of being impaired as a result of the failure of the parents to provide adequate guardianship. The parents had two older CHN removed from their care since 2016 due to the female CH being subjected to excessive corporal punishment. There were additional concerns of her being sexually abused by the SF. The CHN remained in foster care. The parents had not completed the service plan. The SM gave birth to the SC. The concerns for the SC were derivative of the past indicated case.

OCFS Review Results:
ACS contacted the foster care agency and noted that the SM completed parenting skills classes; the SF missed two sessions. The SF completed a sex offender program. The parents were unable to complete counseling and anger management due to limited English proficiency. During a visit to the home the SC was observed co-sleeping with the

SM. ACS discussed the dangers of co-sleeping with the parents and provided a "Pack 'n Play." On 3/20/17, ACS filed an Article Ten petition. On 4/3/17, ACS agreed to withdraw the 1027 request and to release the SC to the parents with ACS supervision on the condition that the SC slept in a crib or "Pack 'n Play."

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)
09/28/2016	Sibling, Female, 9 Years	Father, Male, 49 Years	Inadequate Guardianship	Indicated	No
	Sibling, Female, 9 Years	Father, Male, 49 Years	Sexual Abuse	Indicated	
	Sibling, Female, 9 Years	Mother, Female, 34 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 9 Years	Mother, Female, 34 Years	Lacerations / Bruises / Welts	Indicated	
	Sibling, Male, 3 Years	Mother, Female, 34 Years	Inadequate Guardianship	Indicated	
	Sibling, Female, 9 Years	Mother, Female, 34 Years	Excessive Corporal Punishment	Indicated	

Report Summary:
The 9/28/16 report alleged that on 9/27/16, when the 9-yo-CH misplaced her sweater, out of anger the SM stood behind the CH and hit her on the back of the neck. As a result, the 9-yo-CH sustained red welts and approximately two-inch long bruises on the back of her neck. Later, during dinner when the 9-yo-CH did not like what was for dinner the SM kicked her on the thigh and stomach area. Unknown whether there was a visible injury. Also, the SM had a history of being physically aggressive towards the 9-yo-CH as she had sustained past bruises on her leg area from being kicked. Out of anger the SM had hit the 3-yo-CH as well. Unknown whether he sustained injury.

Determination: Indicated | **Date of Determination:** 12/06/2016

Basis for Determination:
The SM used physical punishment in the home with the 9-yo-CH and she reported she pinched the 9-yo-CH for losing her sweater at school. The 9-yo-CH was observed with two, 2-inch long bruises on her thigh from the SM pinching her through her jeans. The 9-yo-CH also sustained marks and bruising to the neck as a result of the SM hitting her with her hand. The SM threatened to physically discipline the 9-yo-CH if she did not return home with her sweater. The SM's threat scared the 9-yo-CH resulting in her fear of returning home. The 9-yo-CH said the SM slapped her and the 3-yo-CH in the face as a form of punishment. The 9-yo-CH said the SF touched her inappropriately on her chest and vagina.

OCFS Review Results:
ACS learned that the SC and a friend approached a school staff member and requested assistance to locate the 9-yo's sweater. The staff person spoke with the 9-yo CH and took her to the nurse. The CH said she was afraid to go home as she feared the SM would hurt her again. The 9-yo-CH had scratches on her back and two bruises on her right thigh above the knee where she said the SM pinched her. The CH said the SM hit her on the back with her hand as she lost her sweater at school. ACS conducted an emergency removal of the CHN. On 9/29/16, an Article Ten petition was filed in Family Court. COS was granted with an OP against the parents. A remand was granted on 10/3/16.

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

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

The parents were not known to the SCR or ACS as subjects more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 09/29/2016

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 09/29/2016

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

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

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

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐

Additional information, if necessary:
ACS opened the service case and filed an Article Ten petition on 9/29/16 for XCP and SA; the parents were named as the respondents. The two CHN were remanded to foster care. An Article Ten petition was filed on 3/20/17 after the birth of the SC, and Family Court released the SC to the parents with ACS supervision.

Required Action(s)

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

Issue:	Adequacy of Progress Notes
Summary:	ACS documentation for the content requirement for the Family Service Progress Notes (FSPN) were inadequate. The notes were short entries with very little elaboration of what was said and what occurred. The notes did not include details of the visit.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The ACS Family Service Progress Notes were not entered contemporaneously. An event occurred on 4/21/17 but was not entered until 6/16/17.
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.

Preventive Services History

During the 3/16/17 investigation, ACS filed an Article Ten petition in the KCFC on 3/20/17 after the birth of the SC. KCFC released the SC to the parents with court ordered supervision.

ACS did not enter progress notes contemporaneously. Events occurred on 4/21/17 and 10/26/17 but were not entered until 6/16/17 and 2/20/18, respectively. The entries were significantly brief and were inadequate because the progress notes did not include results of interviews, participant responses assessment and outcomes pertinent to the case circumstances. The duration of the visits seemed to be very short. During the month of May 2017, there was no successful home visit to the parents' home; only an attempted home visit by ACS. ACS did not visit the parents' home in September 2017. The last visit conducted by ACS to the parents' home prior to the incident was 11/6/17. Although the visit occurred on 11/6/17, the event was not entered until 2/16/18, and the documentation showed the SC was lying in his crib and did not have marks or bruises.

Required Action(s)

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

Issue:	Appropriateness and adequacy of child's foster care placement
Summary:	Prior to the fatality, the two siblings were placed in a non-kinship home that did not support their ethnic, cultural and language needs. The search for a culturally similar foster home must be ongoing.
Legal Reference:	18 NYCRR 430.11(c) or (d)

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

Foster Care Placement History

During the 9/28/16 investigation, ACS filed an Article Ten Neglect petition on 9/29/16 in Family Court. The two CHN were placed on 10/2/16 and remanded to ACS on 10/3/16. The parents were granted supervised visits with the CHN. Court ordered supervision (COS) was granted with full temporary OP against the parents. The LFCS foster care agency had case planning responsibility. The service plan included: parent training and family support services for the parents, and case management and foster care services for CHN.

The 10/27/17 FASP reflected that the two CHN were placed in a non-kinship foster home. SM attended Anger Management classes and complied with service plan requirements. SM completed parenting classes in December 2016. SF was referred to sex offender and parenting classes in March 2017, but due to limited class availability, he was transferred. On 8/24/17, ACS learned that the counselor had been working with the family for several months, but the SF had recently began the sex offender counseling. The 4-year-old CH received services to address education needs and the 11-year-old CH received therapy. The last visit to the home by LFCS was conducted on 11/15/17. The SC was dressed appropriately and did not have visible marks or bruises.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/29/2016	Adjudicated Neglected	Care/Custody to Local Social Services District
Respondent:	044702 Mother Female 35 Year(s)	
Comments:	The family had an active case in the Kings County Family Court at the time of the fatality. The Article Ten neglect petition was filed on 9/29/16 for XCP and SA; the parents were named as the respondents. The SF reportedly sexually abused the 11-yo-CH. The SM physically assaulted the 11-yo-CH by hitting her excessively in the back of the neck and pinching the CH on her thighs leaving red welts and bruises on her. The two CHN were remanded to foster care under the care of Little Flower Children's Services (LFCS).	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/20/2017	Adjudicated Neglected	Widthdrawn
Respondent:	044703 Father Male 50 Year(s)	
Comments:	An Article Ten petition was filed on 3/20/17 after the birth of the SC. The Family Court released the SC to the parents with court ordered supervision including orders for the parents to comply with services. The SC died on 11/22/17.	

Have any Orders of Protection been issued? Yes	
From: 04/05/2017	**To:** Unknown
Explain: The Family Court issued a limited OP against both parents on behalf of the three CHN stipulating no criminal offenses and no corporal punishment.	
From: 09/29/2016	**To:** Unknown
Explain: The documentation of the 9/28/16 investigation reflected that an Article Ten Petition was filed in Kings County Family Court. Court ordered service was granted with full temporary OP against the parents. The 11/23/17 fatality investigation reflected that there were three active OPs against the SM protecting the 11-yo-CH, 3-yo-CH and SC. Two were Article Ten behavioral that expired on 1/3/18. One was a stay away OP protecting the 11-yo-CH which expires on 3/29/19. There were 13 expired orders against the SM.	

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