Child Fatality Report

Report Identification Number: NY-18-058

Prepared by: New York City Regional Office

Issue Date: Dec 04, 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: 5 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 06/04/2018
Initial Date OCFS Notified: 06/04/2018

Presenting Information

On 6/4/18 and 6/6/18, the SCR registered reports regarding the death of this 5-month-old male child. The reports were registered as subsequent reports as there was an active case dated 5/8/18.

The 6/4/18 report alleged the SC was found unresponsive by the mother on 6/4/18 at 8:55 A.M. and was last seen alive at 2:00 A.M. The report alleged the mother administered an asthma pump; however, it was unknown who had been prescribed this medication as it did not belong to the SC. The report also alleged the SC had no pre-existing medical condition. The report also stated the SC's crib was dirty and cluttered; and the home was cluttered with clothes strewn about and dirty floors. The mother called 911 and the SC was transported to the hospital where he was pronounced dead at 9:25 A.M. The SC had no visible injuries.

On 6/6/18, the SCR registered a report concerning the SC's death which alleged the SC's crib mattress had no sheet and was covered by a fabric mat. There was a blue teething ring and a pacifier in the crib. The SC had multiple inflicted injuries, which included bruises and scrapes to the head and extremities. It was alleged some injuries were new while others were in various stages of healing. The report stated the multiple inflicted injuries led to the child's death. The report described the home was cluttered and dirty with garbage, toys, containers, bikes, and papers strewn about the home; there was also an infestation of roaches.

Executive Summary

The SC was 5 months old at the time of his death. OCFS has not received the official autopsy report; however, the death has been deemed a homicide by the Medical Examiner.

The SC resided with his parents and a 2-year-old sibling. At the time of the SC's death, the father was enrolled in an in-patient drug rehabilitation program. ACS made no effort to locate the father between 5/8/18 and 5/25/18 and there was minimal contact in the ensuing investigation.

The mother had an extensive CPS history with ACS and was known to Family Court in proceedings involving her three older children. These children were removed from the mother's care as a result of an Article 10 Petition of Neglect in 2009, and were subsequently discharged to their father on 10/24/14. The mother had no contact with these children. The mother also had a history of substance abuse, domestic violence, and mental health issues for which she had declined services in the past.

On 5/8/18, the SCR registered a report with allegations of IF/C/S and IG of the 2-year-old and 5-month-old children in the home by the parents. At the time of the SC's death, the 5/8/18 investigation was ongoing, and there was an active case with the Bronx County Family Court (BxCFC) for court ordered supervision (COS).

ACS' Bronx Field Office was assigned the investigation of the initial intake.

A review of the 5/8/18 report reflected ACS did not conduct a thorough investigation or follow regulatory standards. The investigation did not include relevant collateral contacts and ACS did not reach out to the family's resources. During the investigation of this report, there were specific points when timely and appropriate intervention could have assisted the family's functioning; including, on 5/8/18 and 5/9/18, when the family refused to allow CPS entry into the home. The

documentation did not reflect ACS considered an order of entry. Additionally, when the mother disclosed her dislike of physicians, coupled with the fact that the SC and the sibling had not seen a pediatrician in more than 5 months, there was no sense of immediacy or urgency in suggesting the mother have the children assessed by a doctor instead of "as soon as possible". Additionally, there was no urgency to assess the family's functioning. There was no attempt to have a consultation with the Family Court Legal Services (FCLS) regarding the mother's actions or inactions.

On 5/24/18, ACS held a Child Safety Conference (CSC) where the documentation reflected ACS became aware of the mother's daily drug use (marijuana and K-2) while being the sole caretaker of the children. The mother was referred to VIP Community Services agency for services which would include parenting skills training, treatment for substance abuse, and clinical assistance. The documentation did not reflect ACS conducted an assessment of safety or risk in light of the information obtained.

Later, on 5/29/18, ACS filed an Article 10 Petition of Neglect in the BxCFC on behalf of the children and naming the parents as respondents. The petition was filed on the basis of the parents' drug use and failure to participate in a drug treatment program, and the prior neglect of the mother's other children. ACS requested COS. ACS' decision was not consistent with the information gathered as it was known at this point that there were immediate and impending danger to the safety of the children.There was no sense of urgency as it relates to the decision making at this juncture. It was unclear why members of the CPS team present at the CSC did not recommend a remand, as it was the most logical action based on their documentation and case activities at that point.

On 6/4/18 and 6/6/18, the SCR registered two reports concerning the death of the SC. The allegations of the reports were DOA/FATL of the SC; and IF/C/S and IG of the SC and the surviving sibling by the mother and a MU. ACS determined the MU was not a person legally responsible. The father was not added as a subject in the reports. The same team investigating the 5/8/18 report was assigned to investigate the subsequent fatality reports.

Regarding the fatality reports, on 6/4/18, ACS conducted an emergency removal of the sibling and placed her in a kinship home with a paternal aunt (PA). On 6/5/18, ACS filed an Order to Show Cause and amended the existing petition in the BxCFC requesting a remand of the sibling. The Court granted the remand. The sibling was placed in the custody of the Commissioner of ACS under the auspices of Abbott House.

ACS made an assessment of the mother's three other children who were returned to their father in 2014 and documented no concerns regarding the care the father was providing these children. The father reported the mother had no contact with the children since they were released to him.

On 6/11/18, ACS made contact with the Assistant District Attorney (ADA) and discussed the mother's disclosure concerning the abusive events leading up to the SC's death and on the same day, the NYPD arrested and charged the mother with Murder in the Second Degree, Manslaughter, and Endangering the Welfare of a Child. The mother remains incarcerated at the Riker's Island Correctional Facility pending further proceedings.

OCFS noted many deficiencies in ACS' casework practice throughout the initial and subsequent fatality investigations. These included interviews of poor quality, failure to correctly assess the family functioning as it related to possible domestic violence and mental health issues, non-contemporaneous entries of progress notes, lack of cross systems collaboration, significant lapses in the investigative process, failure to contact collateral sources, and lack of direction and guidance from supervisors. In addition, key information was not obtained about the family's dynamics, family strengths and the factors that created safety or risk concerns.

On 7/13/18, ACS indicated the 5/8/18 report against the parents.

As of the writing of this report, the fatality investigations remain undetermined.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
Report remains open as the local district has not yet made a determination.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
While there was evidence of supervisory consultation, there was a lack of supervisory direction or guidance provided during the initial report and the beginning phases of the subsequent fatality reports. The directives were perfunctory and not case specific.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	There were many deficiencies noted by OCFS throughout the ACS investigations. These included interviews of poor quality, failure to correctly assess the family functioning as it relates to possible domestic violence, drug use and mental health issues. There were significant lapses in the investigative process, for example, failure to properly include the father throughout the investigation. The progress notes were not clear and concise and there was no amendment by the supervisor to add clarity to the notes.

	There was also a lack of direction and guidance from supervisors; for example, no directives were provided regarding basic casework practices or next steps. The CPS team appeared to backtrack on actions taken concerning the 5/8/18 report, and did not focus on gathering basic investigative information from the father who they appeared to have discounted throughout the investigations; including after the SC's death and the subsequent placement of the sibling. The father who was still under investigation for the 5/8/18 report could have provided key information concerning the family dynamics and his own background information.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Child Protective Services casework contacts
Summary:	ACS continued to have casework contact with the mother who was incarcerated concerning the planning and her immediate desire to have her relative care for the sibling, but did not discuss these issues in detail with the father and/or his relatives. Throughout the investigation, the casework contacts were not clearly defined as they were specifically geared to the casework circumstances.
Legal Reference:	432.2(b)(4)(vi)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	ACS did not properly address or explore the questions in the RAP which reflected a lack of assessment on this case.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The sibling was placed immediately after the SC’s death; therefore, the safety decisions for all the safety assessments were appropriate. However, the completion of the assessment instrument was convoluted and did not reflect an understanding of the casework actions.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/04/2018 **Time of Death:** 09:25 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 08:55 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Unknown if they were 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	5 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	20 Month(s)
Other Household 1	Father	No Role	Male	49 Year(s)

LDSS Response

Following the receipt of the reports on 6/4/18, the Specialist attempted to contact the EMS, but there was no response.

ACS staff went to the precinct where the mother was being held for questioning. ACS was informed by the detectives the mother and uncle were being questioned. The NYPD denied ACS staff access to the mother, but agreed to notify ACS of the outcome and allow them to participate in the walk through of the case address.

According to the detectives, the mother reported she placed the SC on his belly in the Pack 'N Play, with a blanket, to sleep. The MGU came to the home at 1:00 A.M., and they argued due to the time he arrived at the home. The MGU did not reside in the home, but the mother often allowed him to sleep at the apartment. The detectives stated the mother explained that the MGU slept next to the Pack 'N Play, and left the home between 5:00 A.M. and 6:00 A.M. At that time, the mother checked the SC, and observed that the blanket covered half his face, but he appeared fine. The mother said she went back to sleep and woke again at 8:00 A.M., at which time she found the SC unresponsive. The mother said she attempted to administer the MU's Albuterol pump, in an effort to revive the SC. The mother called 911 at 8:55 A.M. and EMS responded. The CPS asked about the SC being brought to the hospital naked and was told that according to the mother, she left the SC's diaper in the home because it was soiled.

According to the notes entered 6/19/18 for an event which occurred on 6/4/18, the Specialist visited the home and

observed the sibling was dirty and had a scratch on her forehead. The scratch was ½ an inch wide and one inch long. No information was gathered regarding the manner in which the sibling sustained the scratch, as there was no interview with an adult during this visit and the mother was not listed as a participant; the sibling was not able to respond to the questions. An emergency removal was conducted on 6/4/18 and sibling was placed in the care of a PA.

On 6/5/18, ACS requested an Order to Show Cause in the BxCFC and included a request for a remand of sibling. The mother was not present during the hearing as she remained in police custody. The Court Action Summary reflected the father was also listed as a respondent; however, it did not appear he was properly notified of the relevant court dates. The Court granted the remand of the sibling who was placed under the auspices of Abbott House Foster Care agency. The BxCFC granted supervised visits between the father and the sibling but disallowed visit for the mother.

On 6/5/18, the Specialist contacted the pediatric Emergency Room physician from St. Barnabas Hospital and learned the SC was born at 32 weeks gestation. The SC was discharged home after birth. On 6/4/18 the SC arrived at the hospital and was pronounced dead at 9:25 AM. The physician informed ACS there was a small abrasion below the SC's mouth, on the chin. The physician did not express any other concerns and stated an autopsy would be conducted. The physician also informed ACS that the sibling was not examined as there was no request to do so. In a second progress note entered on 6/12/18, ACS' Child Protective Manager (CPM) indicated the sibling was medically examined at the Union Community Health Center on 6/4/18 and was found to be dehydrated. The examination also reflected the need for the sibling's diet to be monitored. ACS did not maintain contemporaneous documentation as the progress note entries from events that occurred prior to the infant's death were recorded days after the infant's death. This raises questions regarding the accuracy and integrity of the account as noted in the record given the delay in transcription and the degree to which the subsequent report influenced the content of what the Specialist documented.

The initial walk through of the home by the NYPD and ACS was attempted on 6/6/18; however, this was unsuccessful as the door was locked and a NYCHA maintenance man reported his supervisor would have to come another day to break open the door.

ACS interviewed neighbors who reported they had no concerns regarding the children. The neighbors expressed shock on hearing of the death of the SC. However, one neighbor told the CPS that the mother was stressed due to her relationship with the father, as he would "play with her (the mother's) emotions." The neighbor denied smelling marijuana coming from the home. Both neighbors indicated they often saw an adult male sleeping in the stairwell and he would appear intoxicated, knocking on the apartment door for 20 to 30 minutes. ACS indicated this male was the mother's uncle.

On 6/6/18, a subsequent report was registered by the SCR noting the SC had multiple inflicted injuries including bruises and scrapes to the head and extremities. Some of these injuries were new while others were in various stages of healing. The report noted that the multiple inflicted injuries led to the child's death. ACS continued the investigation of both reports.

On 6/6/18 the Specialist interviewed the father of the three eldest children. The father reported he had not seen the mother for several years and he was a single parent to his children. The father revealed a volatile relationship with the mother whom he said would often start fights and then blame him. The father reported the children were doing well and they did not "need or want" the mother in their lives.

On 6/8/18 two case conferences were held. The mother agreed to comply with services because she wanted her daughter returned to her care. When confronted with the information that the autopsy showed swelling on the SC's brain, the mother told the CPS team that she shook the SC, placed him on a chair and forgot about him. The SC fell off and started to cry. After he fell, he would not stop crying. The mother said she shook him several times, and when she shook him his head hit the wall. The mother said this was not the first time she had shaken the SC; however, the SC had behaved normally on the previous occasions when he was shaken. The mother said she "blacked out," told the SC to stop crying, and placed him in the Pack 'n Play. The mother said she then left both children in the home and went to the store. When she returned, the SC

was unresponsive. The mother said she tried to revive the SC by placing him under cold water, slapping him in the face and giving him an albuterol pump. The mother said she then waited over an hour to call 911 because she was afraid she would go to jail.

The mother said she never really wanted the SC; she only wanted the sibling. The mother explained that she only had the SC so the father could have a son. The mother said the SC reminded her of the father, and was "difficult" because he cried all the time, unlike the sibling, who was quiet.

The mother said she would not have minded if the SC was removed prior to his death, but did not want the sibling to be removed. When the CPS told the mother the SC's ribs were broken, and that was probably why he cried, the mother stated she did not “murder” her child and that it was an accident. The mother denied she was under the influence of marijuana or K2 at the time of the incident.

The mother said she used a friend for support when she felt overwhelmed and expressed that she did not want the sibling in the father's care. The mother insinuated she did not trust the father as he took too long when cleaning the sibling's vaginal area. She also indicated she did not want the sibling to be with a specific PA and alleged this aunt planned to leave the sibling with an uncle who was a “dope head.”

On 6/9/18, the CPM documented the friend who the mother named as a resource had demonstrated poor decision making regarding the care of the children, therefore, could not be considered as a resource. According to the case documentation, the friend, after learning that the mother had slept with SC on the same bed and awoke to find him wedged between the mattress and the headboard, did not call for emergency medical care, but rather helped to "treat" the SC at home.

ACS met with the ADA and provided information concerning the mother's disclosure. No information was obtained from the ADA.

On 6/13/18, ACS held a conference at the BxFO with the PA who is the kinship foster mother of the sibling. The PA stated she had never met the SC and was not aware of any abuse by the parents. The PA explained the mother kept the children away from the paternal relatives.

Also on 6/19/18 and again on 6/25/18, ACS contacted the ME and learned the SC had bruises on the cheek, forehead, and scalp, in addition to fractures of the rib and skull which were in various stages of healing. On 6/26/18, the sibling had a forensic medical examination after the mother made sexual abuse allegations against the father. The result of the examination was normal.

Also on 6/26/18, the BxCFC amended the Article 10 Petition of Neglect in regard to the father, based on the information he provided at the CSC.

On 7/9/18, ACS spoke to neighbors who had no concerns about the mother’s care of the children.

On 7/12/18 and 7/13/18, the supervisor and CPM, respectively approved the investigation conclusion with no directives or guidance to modify the supporting narratives for the determination of the 5/8/18 report which were convoluted. ACS substantiated the allegations of EXCP, LMC, IG and PD/AM against the parents for both children but did not provide a narrative to support the determination for each parent as it pertains to each child. ACS unsubstantiated the allegation of IF/C/S of the sibling by the parents, but did not provide a narrative to support the unsubstantiation by the mother.

As of the writing of this report the determination of the 6/4/18 and 6/6/18 reports are pending.

Official Manner and Cause of Death

Official Manner: Homicide
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 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
046563 - Deceased Child, Male, 5 Mons	046564 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Pending
046563 - Deceased Child, Male, 5 Mons	046564 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Pending
046563 - Deceased Child, Male, 5 Mons	046564 - Mother, Female, 30 Year(s)	DOA / Fatality	Pending

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 mother did not have a pediatrician for the children.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

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: Sibling in kinship care due to mother's incarceration and father is in an inpatient drug treatment facility.				

Legal Activity Related to the Fatality

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

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
06/11/2018	Mother	Pending	Pending
Comments:	The mother was arrested on 6/11/18 . She is incarcerated pending court proceedings. The next court date is 11/20/18.		

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Mother	Unknown	Pending
Comments:	The next court date is 11/20/18.		

Criminal Charge: Manslaughter **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Mother	Unknown	Pending
Comments:	The mother has been charged with manslaughter in the 1st and 2nd Degree.		

Criminal Charge: Manslaughter **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
06/11/2018	Mother	Unknown	Pending
Comments:	Next court date 11/20/18.		

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:
ACS did not offer services as the mother is currently incarcerated and the father is in a drug treatment facility/program.

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:
In response to the fatality, the sibling was immediately removed and placed in a kinship foster home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother is incarcerated, the father is in an inpatient program. PA will receive training and services associated with being a foster parent.

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?	No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/08/2018	Deceased Child, Male, 5 Months	Father, Male, 51 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 5 Months	Father, Male, 51 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 18 Months	Father, Male, 51 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 18 Months	Father, Male, 51 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 5 Months	Mother, Female, 30 Years	Excessive Corporal Punishment	Substantiated	
	Deceased Child, Male, 5 Months	Father, Male, 51 Years	Excessive Corporal Punishment	Substantiated	
	Deceased Child, Male, 5 Months	Mother, Female, 30 Years	Lack of Medical Care	Substantiated	
	Sibling, Female, 18 Months	Mother, Female, 30 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 5 Months	Father, Male, 51 Years	Lack of Medical Care	Substantiated	
	Sibling, Female, 18 Months	Father, Male, 51 Years	Lack of Medical Care	Substantiated	

Deceased Child, Male, 5 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 18 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Substantiated
Deceased Child, Male, 5 Months	Father, Male, 51 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 18 Months	Father, Male, 51 Years	Parents Drug / Alcohol Misuse	Substantiated
Deceased Child, Male, 5 Months	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 5 Months	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 18 Months	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 18 Months	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated

Report Summary:

The report alleged the parents regularly engaged in verbal and physical altercations in the presence of the children. Allegedly, the most recent incident occurred on 5/5/18 where the parents were heard breaking things in the home. The report also stated there was usually no money available to purchase food for the children, and as a result they were frequently hungry. Further, the report alleged the home was filthy as there was garbage, dirty diapers, food and dishes throughout the home. The report also alleged the parents smoked K2 and the father was seen at the local store, drinking alcohol. It was further alleged there were a lot of people coming in and out of the home.

On 5/8/18, ACS initiated the investigation timely; however, was denied access to the home by someone claiming to be an uncle. The mother also refused to allow ACS to visit the home, but agreed to meet ACS in a parking lot of a fast food restaurant on 5/9/18.

On 5/9/18, ACS documented the children were observed to have no marks or bruises. The mother who was described as "irate" said she wanted "ACS out of her life" and disclosed she "did not believe in doctors," and the children had no pediatrician. The mother stated the SC had not seen a doctor since his discharge from the hospital and that the sibling had last seen a doctor when she was about 5 months old. ACS asked the mother to seek a medical examination for the children the next day. The mother procrastinated and did not follow up until 5/20/18; days prior to the CSC.

The mother reported the children's father was in a drug program and left her with the primary care of the children. The mother denied current use of marijuana and agreed to submit to random screening, but did not do so until after ACS convened a CSC. The Specialist's documentation of the interview with the mother did not reflect the allegations made in the SCR narrative were addressed adequately as the mother provided responses that were not consistent with the history. The documentation did not reflect the Specialist discussed the mother's history as it pertained to the safety of the children.

On 5/21/18, ACS visited the home, but did not provide a clear description of the home or the sleeping accommodations for the children. Prior to this visit, there was no court action taken to request an entry to the home.

Despite being aware of the mother's history, the current information the mother provided, and not being allowed timely access to the home, ACS assessed there was no immediate threat of harm to the children. ACS documented the mother appeared "to have an appropriate behavioral, cognitive, and emotional understanding of protective capacity." This was not consistent with the safety decision documented in the safety assessment.

On 5/24/18, ACS held a CSC and discussed the mother's history, her drug use and mental health concerns. As a result of the CSC, ACS determined that court intervention was needed and proceeded to file an Article 10 Petition for COS. ACS was granted COS with a five-day contingency plan, with the condition that the mother would follow up on the recommendations or a remand would be requested. Based on the documentation, the CSC appeared to focus on services as opposed to the safety of the children. The recommended services did not address immediate safety for the children who were of vulnerable ages. Some services listed were mental health, parenting, substance abuse, and homemaking services. The documentation did not reflect any concerns about the mother's history of not complying with services; the reason her older children were not returned to her care.

ACS filed a neglect petition on 5/29/18 in the BxCFC on the basis of the parents failure to secure medical care, drug use, failure to comply with services, and prior neglect of other children. COS was granted; however, the SC died on 6/4/18. After the death of the SC, ACS returned to court and was granted a remand for the sibling.

Report Determination: Indicated	**Date of Determination:** 07/13/2018

Basis for Determination:
ACS indicated 5/8/18 report. However, the documentation of the narratives in the Investigation Conclusion was convoluted.

ACS substantiated the allegations of EXCP, LMC, IG and PD/AM against the parents for both children. But, did not provide a narrative to support the determination for each parent as it pertains to each child.

ACS unsubstantiated the allegation of IF/C/S of the sibling by the parents, but did not provide a narrative to support the unsubstantiation by the mother.

OCFS Review Results:
The investigation of the prior report was inadequate. There were interviews of poor quality, failure to correctly assess the family functioning as it relates to possible domestic violence and mental health issues, and significant lapses in the investigative process. For example, ACS failed to utilize information from the family's prior history to inform decision-making in the current investigation, failed to contact collateral sources, and failed to contact the subject of the report in a timely manner.

There was also a lack of direction and guidance from supervisors; for example, no directives were provided regarding basic casework practices or next steps, although on 5/9/18 the case was discussed with the manager. In addition, key information was not obtained about the family's dynamics. ACS failed to determine evidence of harm to the children, identify family strengths, or the factors that created safety or risk concerns. The level of casework activity was insufficient for a complete investigation and was particularly lacking given the family circumstances. Case notes were not contemporaneous and were in many instances entered after the death of the child. This raises questions regarding the accuracy and integrity of the account as noted in the record given the delay in transcription and the degree to which the subsequent report influenced the content of what the Specialist documented.

The 7-day Safety Assessment was approved timely, but did not reflect a true assessment of the issues in the home. The mother had not allowed ACS into the home, the children had not been seen by a physician and the issue of the mother's substance misuse was not explored as it related to the family's functioning or the threat of harm to the children. The mother admitted to daily use of marijuana and K2 yet ACS did not take any steps to seek a remand of the children.

Between 5/8/18 and 5/21/18 ACS was denied access to the home, yet there was no referral to ACS' Family Court Legal Services and court action taken to request an entry to the home.

Between 5/8/18 and 5/25/18, ACS made no efforts to locate the father who was allegedly in a drug treatment program. His role with the family was not fully assessed.

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

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

There were many deficiencies noted by OCFS throughout the prior investigation. These included interviews of poor quality, failure to correctly assess the family functioning as it relates to possible domestic violence and mental health issues, significant lapses in the investigative process, for example failure to utilize information from the family's prior history to inform decision-making in the current investigation, failure to contact collateral sources, and failure to contact the subject of the report. There was also a lack of direction and guidance from supervisors; for example, no directives were provided regarding basic casework practices or next steps, although on 5/9/18 the case was discussed with the manager. The allegations of this report were registered with the SCR on 5/8/18, yet the supervisory notes began on 6/4/18 after the SC's death. In addition, key information was not obtained about the family's dynamics, evidence of harm to the children, family strengths and the factors that created safety or risk concerns. The level of casework activity was insufficient for a complete investigation and was particularly lacking given the family circumstances. Case notes were not contemporaneous. The investigation lacked adequate supervisory oversight which impacted on the directives and guidance the Specialist received throughout the investigation.The supervisor repeated written directives and offered no strategy or guidance to address the basic requirement of a CPS investigation; most specifically the access to the home and the contact with the father who was also a subject of this report. The progress notes were not clear and concise and there were no amendment by the supervisor to add clarity to the notes.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

ACS completed the 7-day safety assessment without assessing the conditions of the home or making sufficient collateral contacts within this time period. This included the failure to contact the father who was also listed in the report as a subject. ACS selected a safety decision that noted there was immediate and impending danger of serious harm and selected appropriate safety factors. Such as the mother's CPS history and lack of medical care of her older children whom she no longer had custody of or contact. However, this was not properly explained in the comments or reflected in the actions taken by this point of the investigation. ACS selected the family's history as a safety factor, but did not specify the mother had a history with Family Court and lost custody of her three older children as a result of an Article 10 Neglect Petition for allegations consistent with the ones noted in this report. ACS selected the safety factor noting the mother had failed to seek medical attention for the subject children, but did not note the mother's pattern of not providing medical care for her children based on the history. The comment provided for this safety factor did not reflect an explanation of the impact the mother's inaction had on the safety of the children. Supervisors approved this safety assessment without an appropriate guidance and/or modification.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Progress notes were not entered contemporaneously and were not clear and concise. Documentation of crucial events that occurred prior to the SC's death were entered well after his death. The poor documentation was also evident in the completion of safety assessments and investigation conclusion. The articulation of the supportive narratives was convoluted and did not reflect the presence of critical thinking. Further, NYCRO's review of the FCLS referral form (w856) noted that the form was not completed in its entirety and did not have the signatures of supervisors or FCLS attorney. Despite the administrative change in staff, there was no improvement in directives in this case, specifically in the directives, approval of safety assessments or the investigation conclusion.ACS supervisors must discuss with staff the requirement to maintain accurate and contemporaneous progress notes that clearly document each phase of the investigation process and establish time frames for critical events and must complete a thorough investigation in accordance with 18 NYCRR 432.2 (b)(3), 18 NYCRR 432.2(c) and 18 NYCRR 432.2(c).

Legal Reference:

18 NYCRR 428.5

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

ACS failed to appropriately complete the Risk Assessment Profile, as the investigative documentation did not reflect that the questions in the risk assessment tool were properly addressed or explored. This included the mother's drug use, financial management, housing concerns, domestic violence, parents' cognitive skills, parents' ability to prioritize the children's needs or understanding the seriousness of the current situation.

Legal Reference:

18 NYCRR 432.2(d)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Appropriateness of allegation determination

Summary:

ACS substantiated all the allegations of the children by the parents with the exception of IF/C/S. However, the investigation revealed there was risk of eviction and uncertainty about the parents' ability to maintain the apartment as it was leased to the father who left the apartment to go to the in-patient program. There was no proper financial assessment concerning this issue. ACS based their decision to unsubstantiate this allegation on their observation of the apartment on 5/21/18; which was when the mother allowed ACS access to the home. Previously, on 5/9/18, the mother admitted the home was not organized and this was the reason for delaying ACS' access to the home. The progress notes for the description of the home were not clear and concise. Also, after the SC's death, the ME noted the condition of the home was not clean; specifically the sleeping accommodation for the SC.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Assessment as to need for Family Court Action

Summary:

ACS did not make any effort to obtain an order of entry to conduct a timely assessment of the home. At the time ACS filed the petition for COS, ACS was aware the mother was currently smoking marijuana and K-2. The mother's three older children were not returned to her due to her failure to comply with services and failure to plan. For weeks after the receipt of the 5/8/18 report, the Specialist and Supervisors did not discuss the need for or pursue any legal intervention despite a number of unsuccessful attempts to visit the family's home. In addition, ACS knew of the mother's significant history with Family Court and her mental health concerns. ACS also learned that the children had not seen a physician. However, there was no documentation that the Specialist sought a legal consultation with ACS Division of Legal Services to obtain legal assistance for a remand. No supervisory oversight or instruction was provided regarding this issue. When ACS finally decided on court action, their decision to file for COS after the CSC as opposed to a remand did not reflect a proper assessment of safety and risk for the children. ACS Specialists, Supervisors, and Managers must make timely decisions around safety of all children in the home. Additionally, Supervisors must review the decisions regarding protective removals and provision or mandating other services in accordance with SSL 424(6), 424(11), 18 NYCRR 432.2(b)(3)(vi), 18 NYCRR 432.2(d), 18 NYCRR 432.3(l), FCA 1022 and 1034.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Predetermination/Assessment of Current Safety and Risk

Summary:

ACS was aware of the mother's prior CPS history which led to an Article 10 Neglect Petition and the subsequent removal of her three older children. The mother failed to comply with the mandated court services and did not continue to plan for these children. At the inception of this report, it was evident that the case could have been viewed as derivative abuse/neglect based on the mother's open admission that she was not providing medical care for the two younger children she had in her care and the reported conditions of home. These allegations were similar to those involving her older children; therefore, ACS should have been able to properly assess the safety and risk to the younger children. Yet, a summary of the history was repeatedly documented in the notes with no consideration of legal action until the subsequent death of the SC.

Legal Reference:

18 NYCRR 432.1(aa)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Adequacy of face-to-face contacts with the child and/or child’s parents or guardians

Summary:

Between 5/8/18 and 6/19/18, there was no face-to-face contact with the father who was the subject of the report.

Legal Reference:

18 NYCRR 432.1 (b)(3)(ii)(a)

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

Between 1998 and 2005 the mother was listed as a child in five reports, all of which were indicated.

Between 2008 and 2015, the mother was listed as a subject in six indicated reports dated 8/10/08, 12/22/08, 2/10/09, 3/24/09, 8/7/09 and 11/11/10. The allegations of these reports were: PD/AM, LMC, IF/C/S, EdN and IG.These reports involved the mother's children from previous relationships. The reports revealed a pattern of the mother becoming aggressive and her aggression was also directed at the CPS workers. The reports also revealed the mother's daily use of marijuana, the presence of DV in the home, and a failure to follow up with the medical care of the children.

On 11/11/10, a report was made after the mother gave birth to a male child and he tested positive for marijuana. The mother admitted to smoking marijuana the morning she gave birth. The child's father also admitted to marijuana use, but claimed he had a prescription due to Glaucoma. Both parents failed to cooperate with drug treatment. As a result, an Article 10 Neglect Petition was filed and the children were removed. The children were placed on 11/16/10 under the auspices of Abbott House Foster Care agency.

By March 2012, both parents provided negative drug screenings and although services were not fully implemented, the court granted an "extended family visit;" however, due to domestic violence, and lack of food in the home and the children were returned to foster care. The mother stopped regular communications with the agency following the children's return to care and her last contact and visit with the children was on 7/23/14. The children were ultimately discharged to their father on 10/24/14. The father and the children resided in a family shelter and eventually obtained a NYCHA apartment on 4/3/15. The FSS was closed on 4/1/15.

There was no contact with the family again until May 2018.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Foster Care Placement History

The mother had three other children from a previous relationship who were in foster care and subsequently discharged to their fathers.

On 5/19/09, ACS filed an Article 10 Neglect Petition at the Bronx Family Court naming the mother as a respondent concerning her three older children. ACS was granted COS; however, the children were subsequently removed on 11/16/10, and later discharged from foster care to their father. The mother failed to comply with services and discontinued her visits with the siblings.

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:**
05/29/2018	There was not a fact finding	Order of Supervision
Respondent:	046564 Mother Female 30 Year(s)	
Comments:		

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