Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-031

Prepared by: New York City Regional Office

Issue Date: Aug 11, 2020

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 18 day(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 03/21/2020
Initial Date OCFS Notified: 03/21/2020

Presenting Information

The report alleged on 3/21/20, the SC was at home, and in the care of the SM. The SM woke up shortly prior to 8:50 AM and checked the SC and found the SC unresponsive. It was unknown where the SC was located inside the home, or the condition of the SC's immediate surroundings when the SM found the SC unresponsive. At 8:50 AM, the SM called 911. At 9:01 AM, when EMS arrived to the home, the FDNY was already at the home and was performing CPR on the SC. At this time, the SC was observed to have blood on her face underneath her nose. The cause of the blood on the SC's face was unknown. Further details on the condition of the SC's body were unknown. The SC was transported to a hospital and pronounced dead. The cause of the SC's death was unknown. The lack of an explanation for the SC's death made the death suspicious in nature.

Executive Summary

The 2-week-old female child (SC) died on 3/21/20. As of 8/11/20, NYCRO had not yet received a copy of the autopsy report.

The allegations of the 3/21/20 report were DOA/Fatality and IG of the SC by the SM and SF.

ACS learned that on 3/21/20, at about 4:45 AM, the SM fed the SC. The SM burped the SC and she seemed fine. The SM then placed the SC's pillow and sheet flat between her and the SF and placed the SC on her back to sleep on the full-size bed. At an unknown time, the SM awoke, and she touched the SC's arm and found the SC unresponsive. The SM saw blood coming from the SC's nose and then woke the SF. They checked the SM's phone and tablet which were not charged, and then the SF went upstairs and requested a neighbor call 911. The SM went outside with the SC in her arms to seek help, but no one was outside. The SM and SF woke the other CHN, walked to the car, and when they arrived at the car, it did not start. The FDNY responded and a concerned citizen directed them to the SM. An ambulance arrived and transported the SC to the hospital. The SM was aware of safe sleep practices.

According to the SF, when he awoke, he saw the SC had blood coming from her nose and mouth. He went to a neighbor, but she did not open her door. He went outside to obtain assistance, and someone called LE. The SF went in the home to prepare the other CHN and he obtained assistance from a friend to go to the hospital.

On 3/24/20, a conference occurred, and the outcome was Court Ordered Supervision and bereavement counseling. Later, the Family Court Legal Service (FCLS) delayed the filing of an Article Ten Neglect petition and recommended referral for the needed services.

On 4/13/20, ACS contacted a provider agency to attempt to refer the family for bereavement counseling. However, the effort was unsuccessful. Later, the SM said she was not interested in any services for the family.

The SCR registered a report regarding the family on 6/4/20. The report included the allegation of IG of the 3-yo SS by the SM and SF. On 6/5/20, ACS filed an Article Ten Neglect petition in Family Court naming the SM and SF as the respondents. The twin 5-yo SSs were released to the care of their BF and PGM. The 3-yo SS was remanded to the Commissioner of ACS. On 6/25/20, the placement of the 3-yo SS with the SC's PGM was completed. On 8/3/20, ACS indicated the 6/4/20 report.

As of 8/11/20, ACS had not yet determined the 3/21/20 investigation.

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?** 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

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:
As of 8/11/20, the case remained open for services.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-Hour Child Fatality Summary Report was not completed in a timely manner as it was not completed until 3/23/20.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
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 Seven Day safety assessment document was inadequate as the associated comment did not explain whether the BM's clinical health concerns had a negative impact on her ability to supervise, protect and/or care for CHN
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/21/2020 **Time of Death:** 09:30 AM

Time of fatal incident, if different than time of death: 08:50 AM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 08:54 AM
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
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	Female	18 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)

LDSS Response

On 3/21/20, the medical personnel said the SC had blood from her nose to her top lip and was pronounced dead at 9:30 AM. The medical personnel stated that the SC had no underlying chronic conditions and was born healthy.

On 3/21/20, LE confirmed the SM was co-sleeping with the SC and the SF. LE said according to the SM, after feeding the SC, she put the SC in the bed between her and the SF. The SSs were in the home, but they were well with no signs of abuse. LE said there were no signs of alcohol or drugs. Later, LE said debris were observed on the floor by the door, and there was “not enough living space for the CHN.”

On 3/21/20, the SM reported that at about 4:45 AM, the SC cried, and she fed the SC. Per the SM's account, she burped the SC and she seemed fine. She then placed the SC’s pillow and sheet flat between her and the SF and placed the SC on her back to sleep. At an unknown time, when she awoke, she touched the SC's arm, but she was unresponsive. She saw blood coming from the SC’s nose and then woke the SF, who went upstairs and requested a neighbor call 911. She went outside with the SC to seek help, but no one was outside. The SM and SF woke the other CHN and walked to the car, but it did not start. ACS attempted to speak with the 3-yo SS, who did not respond. The twin SSs were in their PGM's home.

Later, ACS interviewed the SM and obtained additional information. The SM said she saw the SC had blood in her nose and mouth. She said someone called LE as the FDNY arrived. The SM told ACS the SC usually slept in the playpen bassinet but sometimes slept with her and the SF. According to the SM, the ME informed her the SC had pre-existing medical conditions. The SM said when the SC was discharged from the hospital on 3/6/20, she was told the SC had a medical condition, but could be discharged. The SM denied substance abuse and declined a drug test. The SF was interviewed, and his account was similar to the SM’s. The SF denied substance abuse and declined to take a drug test.

On 3/23/20, the SM informed ACS about the arrangements with the three SSs. The twin SSs were with their PGM and the 3-yo SS was with the SC’s PGM. Later, the SC’s PGM said the SF informed her he was told the SC probably had a medical condition. ACS observed the 3-yo SS at the home of the SC’s PGM. The 3-yo SS was not observed with marks or bruises.

On 3/23/20, a neighbor reported the SF knocked on the door in the morning. She did not answer but contacted LE. She said the SM and SF used marijuana.

On 3/24/20, ACS interviewed the 5-yo twin SSs at the home of their PGM. Per twin B's account, the SC slept with the SM in the middle of the bed. The twin A said the SF’s friend took them to the hospital. The PGM had no concerns for the SM’s ability to care for the SSs.

On 3/27/20, the daycare reported that there were no concerns regarding the 3-yo SS. The twin SSs previously attended the daycare and there also were no concerns.

On 4/15/20, the SM informed ACS that the twin SSs returned home. The three SSs were in the legal care of the SM.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The case documentation did not reflect there was an MDT response.

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
054360 - Deceased Child, Female, 18 Days	054362 - Mother, Female, 25 Year(s)	DOA / Fatality	Pending
054360 - Deceased Child, Female, 18 Days	054362 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Pending
054360 - Deceased Child, Female, 18 Days	054363 - Father, Male, 24 Year(s)	DOA / Fatality	Pending
054360 - Deceased Child, Female, 18 Days	054363 - Father, Male, 24 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
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 twin SSs were enrolled in a Childhood Development Program. The documentation reflected the school was closed.

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:
On 6/5/20, ACS filed an Article Ten Neglect petition in Family Court naming the SM and SF as the respondents. The twin 5-yo SSs were released to the care of their BF and PGM. The 3-yo SS was remanded to the Commissioner of ACS.

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:
On 6/5/20, ACS filed an Article Ten Neglect petition in Family Court naming the SM and SF as the respondents. The twin 5-yo SSs were released to the care of their BF and PGM. The 3-yo SS was remanded to the Commissioner of ACS.

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No

Explain:
ACS offered the SM bereavement services; however, the SM declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ACS offered the SM bereavement services; however, the SM declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/08/2018	Sibling, Female, 3 Years	Mother, Female, 23 Years	Lack of Supervision	Unsubstantiated	Yes
	Sibling, Female, 3 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 23 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 23 Years	Lack of Supervision	Unsubstantiated	

Sibling, Male, 1 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 3 Years	Other Adult - birth father of 1-yo, Male, 23 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 3 Years	Other Adult - birth father of 1-yo, Male, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 3 Years	Other Adult - birth father of 1-yo, Male, 23 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 3 Years	Other Adult - birth father of 1-yo, Male, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 1 Years	Other Adult - birth father of 1-yo, Male, 23 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 1 Years	Other Adult - birth father of 1-yo, Male, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
The report alleged the SM and BF regularly drank alcohol and smoked marijuana to impairment where they were unable to adequately care for the CHN. The SM and BF had multiple people at the home each day and they stayed up all hours of the night partying, drinking and using drugs. The SM and BF slept all day and left the CHN home alone unsupervised. The CHN were often seen running around the building and outside unsupervised.

Report Determination: Unfounded | **Date of Determination:** 10/01/2018

Basis for Determination:
During the investigation, ACS learned that the SM and BF of the 1-yo SS provided the three CHN with a minimum degree of care in regard to sufficient food, clothing, adequate supervision, and up to date medical care. A neighbor said the SM and BF did not have many visitors. The neighbor added that the CHN played outside, but were always supervised by the parents. The neighbor reportedly saw the SM and BF smoke cigarettes, and take turns going outside and alternate with supervising the 1-yo SS inside the home. During the home visits, ACS did not observe the SM and BF to be under the influence or intoxicated.

OCFS Review Results:
On 8/8/18, ACS interviewed the SM and BF of the 1-yo SS. The SM informed ACS that she and the three CHN lived in the home and the BF visited them. However, the BF told ACS that he resided at the home. The SM said she drank alcohol occasionally and used marijuana before she had CHN. She said she did not permit anyone who smoked or consumed alcohol to partake in harmful activities around the CHN. The SM told ACS that the visitors were not with the CHN. The BF said he used marijuana but not in the presence of the CHN. He said his friends visited the home. ACS interviewed daycare staff, who said there were no concerns.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The Seven Day safety assessment document was inadequate as there were comments that did not support the selected safety factors. The comment reflected the SM and BF had a chronic history of substance abuse; however, the comments did not explain whether the SM and BF's drug use had a negative impact on the care they provided the CHN.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/07/2017	Sibling, Female, 2 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The report alleged on 3/7/17, while at court, the SM told one of her 2-yo twins (unknown which one) to stop doing what she was doing. The 2-yo did not stop. As discipline, the SM hit the CH in the face causing the CH to cry. The SM's actions were excessive given the age of the CH and the CH's limited capacity to understand why she was hit. The role of the other 2-yo CH was unknown.

Report Determination: Unfounded **Date of Determination:** 05/15/2017

Basis for Determination:
ACS unsubstantiated the allegation of the report on the basis of no credible evidence. ACS explained that the agency interviewed and assessed the 2-yo, and there were no suspicious marks or visible bruises on the 2-yo's body. ACS spoke with the SM about appropriate discipline. The three CHN had no suspicious marks or bruises.

OCFS Review Results:
On 3/8/17, the SM told ACS that one of the twins ran around after she was told her to keep still. The SM was accompanied to the Family Court by her paramour. Per the SM's account, she held the 2-month-old SS, twin B was by her side and twin A ran towards the escalator. The SM ran to prevent her from falling down the escalator. When she grabbed Twin A, she hit her in the mouth with an open hand and told her to stop running. ACS did not observe suspicious marks/bruises on the CH. ACS obtained information from collateral contact, who reportedly observed the incident but did not see the SM's hand make contact with CH. ACS discussed safe sleep with the SM.

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

Issue:
Case record contains information that relevant, useful, factual and objective

Summary:
The CPS Investigation Summary was incorrect as the address listed for Twin B and the 2-month old SS was not reflected in the Investigation Progress Notes.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

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.

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

There is no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The FSPN were not entered contemporaneously. An event occurred on 5/29/17 but was not entered until 7/19/17.
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.

Preventive Services History

After the conclusion of the 3/7/17 investigation on 5/15/17, ACS opened a preventive services case for the family on 5/19/17. The Family Service Progress Notes (FSPN) reflected the case was opened to provide PPRS and Early Intervention (EI) for the CHN. The FSPN also showed the family applied for housing through the Department of Homeless Services (DHS) and the family entered the shelter system on 5/28/17. The family accepted conditional housing placement. On 7/10/17, ACS visited the family and interviewed the SM, who stated they were in temporary housing until DHS was able to complete further processing.

ACS did not complete the required FASP. The family did not receive PPRS, and ACS closed the case on 7/20/17.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

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

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