# NYS Office of Children and Family Services - Child Fatality Report

**Report Identification Number: NY-16-103** **Prepared by: New York City Regional Office**

**Issue Date: 12/13/2016**

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

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

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

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

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

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

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

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

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

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

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

## Abbreviations

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

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

## Case Information

**Report Type:** Child Deceased
**Age:** 6 year(s)
**Jurisdiction:** New York
**Gender:** Male
**Date of Death:** 09/26/2016
**Initial Date OCFS Notified:** 09/26/2016

### Presenting Information

The State Central Register (SCR) registered a report noting that the mother brought the subject child to St. Luke's Hospital's Emergency Room on 9/26/16. It was alleged that the subject child was deceased at the time of arrival to the Emergency Room and the mother did not offer any explanation as to why the subject child was dead. The subject child was observed with subconjunctival hemorrhage, bruising to his torso, abdomen, neck and arms, scratch on his left neck and a small laceration on left side of his head.

### Executive Summary

The 6-year-old child died on 9/26/16. OCFS has not received the official autopsy report from the Medical Examiner; however, the preliminary cause of death was chronic abuse trauma injuries consistent with inflicted trauma and the manner of death was homicide.

On 9/26/16, the SCR registered a report concerning the death of the child. The allegations of the report were Dead On Arrival/Fatality, Internal Injuries, Lacerations/Bruises/Welts, and Inadequate Guardianship of the child by the mother. The Administration for Children's Services (ACS) later added the mother's partner as a subject of this report with the same allegations. Law enforcement confirmed there are no surviving children in the home.

The family had been known to ACS in five SCR reports between 6/22/10 and 4/18/16. Three reports, dated 6/30/15, 8/31/15, and 2/2/16, were indicated, and two dated 6/22/10 and 4/18/16 were unfounded. The mother's partner was listed as the subject of two of the indicated reports. The reports contained repeated allegations of Parent Drug/Alcohol Misuse, Fractures, Excessive Corporal Punishment, and Inadequate Guardianship of the child by the mother and the mother's partner.

The family also received preventive services through St. Luke's Roosevelt Hospital Family Treatment Rehabilitation from 8/28/15 until 9/24/16 when the case was closed in CONNECTIONS. Furthermore, the family was known to the homeless shelter system as the mother and the child had been in shelter placements from 10/18/11 until 7/14/16 when she was discharged from the shelter due to frequent absences.

A review of the prior reports reflected ACS did not conduct thorough investigations and/or follow regulatory standards. The investigations did not include relevant collateral contacts and ACS did not reach out to the family's resources. During the investigation of the prior reports there were specific points when timely and appropriate intervention could have assisted the family's functioning. There were many deficiencies noted by OCFS throughout all of the ACS 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, 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, evidence of harm to the child, family strengths and the factors that created safety or risk concerns. The level of casework activity for all cases was insufficient and was particularly lacking given the family circumstances.

OCFS' review of the preventive services case also reflected the family was not fully engaged, referrals for mental health and substance abuse services were not addressed, and when the preventive services case planner identified evidence of possible abuse and/or maltreatment, no report was made to the SCR.

As of 12/1/16, ACS has not yet made a determination on the fatality report registered by the SCR on 9/26/16 and has not updated the case information in CONNECTIONS since 10/18/16.

There are no required actions specific to the investigation of the fatality, however, based on the whole of the review, OCFS directs ACS to address the following required actions within 45 days (1/28/17) of the issuance of the Final Report:

New York State directs ACS to hire an external, OCFS approved monitor, by 1/28/17, to conduct a comprehensive evaluation of ACS' Child Protective and Preventive services programs. The monitor will be required to issue monthly reports to OCFS and ACS.

New York State directs ACS to conduct a full evaluation of caseworkers, case supervisors, and borough managers in the Manhattan Field Office to assess competencies, strengths and weaknesses and take the appropriate action necessary to respond to any identified issues.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

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

**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:**
The CPS report had not yet been determined at the time this fatality report was issued

**Was the decision to close the case appropriate?** Unknown

**Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?** Unable to Determine

**Was there sufficient documentation of supervisory consultation?** No

**Explain:**
The CPS report had not yet been determined at the time this Fatality report was issued

## Required Actions Related to the Fatality

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

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 09/26/2016 **Time of Death:** 02:41 PM

**County where fatality incident occurred:** New York
**Was 911 or local emergency number called?** Yes
**Time of Call:** Unknown
**Did EMS to respond to the scene?** Yes
**At time of incident leading to death, had child used alcohol or drugs?** N/A
**Child's activity at time of incident:**

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

**Did child have supervision at time of incident leading to death?** Unable to determine

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

### Household Composition at time of Fatality

| Household | Relationship | Role | Gender | Age |
|---|---|---|---|---|
| Deceased Child's Household | Deceased Child | Alleged Victim | Male | 6 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 26 Year(s) |
| Deceased Child's Household | Mother's Partner | Alleged Perpetrator | Male | 42 Year(s) |

### LDSS Response

According to the case record, on 9/26/16, the mother called 911 when she found the subject child unresponsive, but did not wait for Emergency Medical Services to arrive. The mother took a taxi to St. Luke's Hospital where she arrived with the child in her arms, not breathing. The child was pulseless and showed no vital signs. The medical staff immediately began resuscitation efforts to no avail. The subject child was pronounced dead at 2:41 pm on 9/26/16.

The social worker noted the mother arrived at the hospital at 2:34 pm holding the subject child, saying he was not breathing. The mother first said the child fell from his bed in the night, onto his head. The social worker heard the mother tell the New York Police Department (NYPD) she had last seen the child at her sister's house and then continued to change

her account. The mother did not provide the social worker information about her partner or the aunt whom the child had allegedly recently visited. Later in the investigation, the mother's family said they had not seen mother or child for months prior to the fatality.

ACS spoke with the mother's relatives, who had no current information about the mother or events leading to the subject child's death; they had not seen the child in a while. Further, the family did not know much about mother's partner. The maternal great-grandmother said she did not have a close relationship with the mother and had last seen the child at a family gathering on 7/11/16. The maternal great aunt said that on 7/11/16, the subject child was spending time with a maternal aunt and the aunt had brought the child to her home. The great aunt said she noticed he had a mark on the back of his neck and a few cuts on his head. The child told her mother's partner had been cutting his hair and held his neck so he would stay still. The maternal great uncle said he had not seen the mother for a while but on 8/28/16 he had a conversation with her. She reported the subject child was "being bad," "jumping on the people['s] couch and not listening" to his mother. The great uncle said he spoke to the mother and emphasized the child was only 6 years old and was supposed to play and he was not bad. The great uncle said he told the mother he hoped she and her partner were not mistreating the subject child.

The doctor at St. Luke's Hospital reported to ACS the injuries observed on the child, noting the child appeared to be 3 years old. The Medical Examiner indicated the subject child's body temperature was 80 degrees Fahrenheit at the time he arrived to the Emergency Room, making it possible the child had been dead about 17 hours prior to his arrival there. NYPD informed ACS the incident leading to the subject child's death occurred at the mother's partner's home, which was in deplorable condition.

The NYPD held the mother for questioning, but did not allow ACS to participate or observe the interview with the subjects of the report. On 9/26/16 NYPD advised ACS it would not be possible to interview the mother. NYPD later informed ACS that the mother and her partner were arrested and charged with Endangering the Welfare of a Child; no details were provided to ACS. NYPD informed ACS that the mother and her partner were held on bond and were due to return to court 10/13/16. ACS was instructed by the District Attorney's Office to refrain from contacting individuals with knowledge of the case.

ACS reviewed the New York City Department of Education's Attendance Tracking System and although the child had not attended school since the beginning of this school year, it was noted in error the subject child had attended school on 9/23/16. The school made the adjustment to the attendance record. ACS did not obtain the subject child's medical records from the pediatrician.

As of 12/1/16, ACS has not updated the information in CONNECTIONS since 10/18/16. As of this writing, ACS has made no determination for this report.

## 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 |
|---|---|---|---|
| 031268 - Deceased Child, Male, 6 Yrs | 031561 - Mother's Partner, Male, 42 Year(s) | Internal Injuries | Pending |
| 031268 - Deceased Child, Male, 6 Yrs | 031561 - Mother's Partner, Male, 42 Year(s) | DOA / Fatality | Pending |
| 031268 - Deceased Child, Male, 6 Yrs | 031561 - Mother's Partner, Male, 42 Year(s) | Inadequate Guardianship | Pending |
| 031268 - Deceased Child, Male, 6 Yrs | 031561 - Mother's Partner, Male, 42 Year(s) | Lacerations / Bruises / Welts | Pending |
| 031268 - Deceased Child, Male, 6 Yrs | 031269 - Mother, Female, 26 Year(s) | Inadequate Guardianship | Pending |
| 031268 - Deceased Child, Male, 6 Yrs | 031269 - Mother, Female, 26 Year(s) | DOA / Fatality | Pending |
| 031268 - Deceased Child, Male, 6 Yrs | 031269 - Mother, Female, 26 Year(s) | Lacerations / Bruises / Welts | Pending |
| 031268 - Deceased Child, Male, 6 Yrs | 031269 - Mother, Female, 26 Year(s) | Internal Injuries | 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?** | ☐ | ☒ | ☐ | ☐ |
| **Case Planners** | ☐ | ☒ | ☐ | ☐ |
| **Pediatrician** | ☐ | ☒ | ☐ | ☐ |
| **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:**

As of 12/1/16, ACS has not updated progress notes in the CONNECTIONS database since 10/18/16 . OCFS was informed by the Associate Commissioner of ACS's Division of Child Protection on 10/6/16 that due to the directive from the District Attorney's Office, there has been no case activity regarding the investigation. Law enforcement and the District Attorney's Office denied ACS access to the subjects of the report.

## Fatality Safety Assessment Activities

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

## Legal Activity Related to the Fatality

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

☐Family Court ☒Criminal Court ☐Order of Protection

| **Criminal Charge:** Endangering the welfare of a child | | **Degree:** NA | |
|---|---|---|---|
| **Date Charges Filed:** | **Against Whom?** | **Date of Disposition:** | **Disposition:** |
| 09/26/2016 | Mother's partner | Pending | Unknown |
| **Comments:** | No information regarding the charges has been entered in the CONNECTIONS database. | | |

| **Criminal Charge:** Endangering the welfare of a child | | **Degree:** NA | |
|---|---|---|---|
| **Date Charges Filed:** | **Against Whom?** | **Date of Disposition:** | **Disposition:** |
| 09/26/2016 | Mother | Pending | Unknown |
| **Comments:** | No information regarding the charges has been updated in the CONNECTIONS database. | | |

## Services Provided to the Family in Response to the Fatality

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

**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?** N/A
**Explain:**
There were no surviving siblings or other children in the home.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** No
**Explain:**
The mother and the mother's partner were arrested after the subject child's death.

## History Prior to the Fatality

## Child Information

| | |
|---|---|
| **Did the child have a history of alleged child abuse/maltreatment?** | Yes |
| **Was there an open CPS case with this child at the time of death?** | No |
| **Was the child ever placed outside of the home prior to the death?** | No |
| **Were there any siblings ever placed outside of the home prior to this child's death?** | N/A |
| **Was the child acutely ill during the two weeks before death?** | No |

## CPS - Investigative History Three Years Prior to the Fatality

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 04/18/2016 | 11430 - Deceased Child, Male, 6 Years | 11431 - Mother's Partner, Female, 26 Years | Inadequate Guardianship | Unfounded | Yes |
| | 11430 - Deceased Child, Male, 6 Years | 11431 - Mother's Partner, Female, 26 Years | Lacerations / Bruises / Welts | Unfounded | |

**Report Summary:**

On 4/18/16, the SCR registered a report with allegations of Lacerations/Bruises/Welts and Inadequate Guardianship of the subject child by the mother. The report alleged that the child arrived at school with multiple bruises and scratches on both legs, and while there were multiple explanations for the injuries, none were consistent with the injuries. Upon arriving to school, the child appeared to be in pain. He was examined by the nurse and found to have multiple bruises and scratches on his leg. The child said he fell off a scooter; he also added that his cousins had been hitting him. The child had a history of presenting with minor injuries but the current injuries were the worst.

The child was taken to the Manhattan Child Advocacy Center (CAC) for a joint interview with a detective. The ACS case record noted the mother was heard asking the subject child whether he had told school staff the “truth.” The mother was upset with the child about the new report, telling the child if he had just told the truth the “school would back off.” The mother denied the allegation and claimed that over the weekend the child had been in Brooklyn with a maternal aunt. ACS did not follow up with the aunt in Brooklyn to ascertain the credibility of the mother’s account. Following the child's death, maternal relatives said they had not seen the child in months.

ACS documentation reflected an interview with the subject child at the Child Advocacy Center. ACS documentation reflected the child was found to have “irritation” on his legs, red in color-very faint, no marks or bruises observed. This was inconsistent with the detailed documentation provided by the school nurse regarding the child's injuries. The child reported that when he did not behave he was spanked, but the Child Protective Specialist (Specialist) did not ask the child to specify who spanked him. The child also noted he did not “get to eat good ” if he was "bad." The child stated he “gets bruises on his head and knees.”

On 4/19/16, ACS informed the preventive services case planner of the new report registered by the SCR and of a school meeting scheduled later the same day. The case planner, nurse, teacher, ACS representatives, and mother attended the meeting. There was discussion of the services the child was receiving in school and also the tardiness, especially since the child resided only a block away from school. ACS was also informed that the subject child was observed by the teacher, social worker, and case planner with a mark on his face as recently as 4/12/16. No new reports were registered at

the time of these observations.

On 4/25/16, the Supervisor II conducted a 5-Day Review and summarized the actions taken since the report was received for investigation. The supervisor documented there were no recent marks observed on the child as reported, and that the subject child did not disclose any abuse. The Supervisor noted that the child would be scheduled for medical assessment at the Child Advocacy Center. The documentation did not reflect that a medical exam was completed. The Specialist was instructed to follow up with the Child Advocacy Center regarding the medical assessment.

On 5/6/16 the Specialist obtained the criminal background and domestic violence checks for the mother and her partner. ACS did not address the information with the mother. This information was in addition to information on domestic violence obtained and addressed on 9/8/15.

On 5/9/16, the Specialist visited the mother's shelter apartment. The mother and subject child were home. The mother indicated she was closely supervising the child as she was "afraid something else may happen" to the child, but did not elaborate further. The mother indicated they would be receiving a housing voucher and wanted to move to Brooklyn. The Specialist documented the child was clean and well-groomed and the unit was clean and had adequate food.

| **Determination:** Unfounded | **Date of Determination:** 05/10/2016 |
|---|---|

**Basis for Determination:**
On 5/10/16, twenty-three days after the report was received ACS unsubstantiated the allegations of the report. ACS unsubstantiated the allegations of Lacerations, Bruises, Welts and Inadequate Guardianship of the subject child by the mother and noted there was no evidence the mother was negligent with the child, who had been "examined" and interviewed at the Child Advocacy Center and was found without marks or bruises. Law Enforcement did not pursue criminal charges against the mother.

**OCFS Review Results:**
The investigation of this report was grossly incomplete and lacked supervisory and managerial oversight. The ACS documentation was convoluted with no focus on attempting to grasp an understanding of the subject child's account of events leading to the injuries. ACS did not effectively utilize the 60 days provided for the investigation of the report. In spite of the high priority designation, based on ACS's protocols, from the receipt of the report there was no managerial review until 5/10/16. Additionally, the decision to unsubstantiate the allegations of the report was inappropriate. This decision did not take into consideration the observations provided by school staff concerning the marks and bruises observed on the subject child. In addition, it did not consider that the mother failed to keep the medical appointment scheduled for the child to return to the Child Advocacy Center.

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

**Issue:**
Overall Completeness and Adequacy of Investigation

**Summary:**
The investigation of this report was grossly incomplete and lacked documentation, proper casework assessment, and supervisory and managerial oversight. ACS failed to verify that supervisory directives were completed prior to case closure. ACS did not effectively utilize the 60 days provided for the investigation of the report. In spite of the high priority designation from the receipt of the report, there was no managerial review until 5/10/16 when the case was submitted for closure. ACS completed their investigation in 23 days without making adequate collateral contacts, disregarding information from mandated reporters of concerns for the safety of the Subject Child, not reaching out to relatives or having a legal consultation on this case. In addition, ACS did not conduct a thorough review of the Family Services Stage which indicated that the assigned preventive services agency had not been properly monitoring the home. The mother was referred for preventive services in August of 2015 and had not engaged in clinical services.

**Legal Reference:**

SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)

**Action:**

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

**Issue:**

Failure to provide notice of report

**Summary:**

ACS did not search for the subject child's father; therefore, the Notice Of the Existence of a report was not issued for him.

**Legal Reference:**

18 NYCRR 432.2(b)(3)(ii)(f)

**Action:**

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

**Issue:**

Contact/Information From Reporting/Collateral Source

**Summary:**

ACS completed their investigation in 23 days without making adequate collateral contacts, disregarding information from mandated reporters of concerns for the safety of the subject child, and without reaching out to relatives to verify statements from the parent and subject child regarding the child's injuries.

**Legal Reference:**

18 NYCRR 432.2(b)(3)(ii)(b)

**Action:**

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

**Issue:**

Pre-Determination/Nature, Extent and Cause of Any Condition

**Summary:**

ACS unfounded the allegations of the report without considering medical information from the school nurse who conducted an external examination and provided details of the subject child's injuries. This was a misapplication of the definition of neglect pursuant to the Family Court Act 1012(f). ACS made a premature determination as they did not utilize the 60 days provided to complete the investigation of the report. At the time of the determination ACS had not fully explored the allegation to properly make a determination.

**Legal Reference:**

18 NYCRR 432.2(b)(3)(iii)(c)

**Action:**

ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action 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 unfounded the allegations of the report without considering medical information from the school nurse who conducted an external examination and provided details of the subject child's injuries. This was a misapplication of the definition of neglect pursuant to the Family Court Act 1012(f). ACS made a premature determination as they did not utilize 60 days provided to complete the investigation of the report. At the time of the determination ACS had not fully explored the allegation to properly make a determination.

**Legal Reference:**
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action 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:**
During the course of the investigation, ACS completed the required Safety Assessments inappropriately as they did not reflect the circumstances of the case. ACS documented that there were safety factors which did not rise to the level of immediate or impending danger of serious harm. However, based on the information gathered during this investigation ACS should have selected safety decision 3 as there were apparent imminent and immediate safety concerns. ACS only selected the mother's history as a safety factor. These safety assessments should have included judicial intervention, because there were medical collaterals that documented in detail the injuries the subject child sustained. In addition, there was an ongoing pattern of reports that involved the child being physically harmed. Further, the school staff in the present and past reports emphasized the concerns about the number of alleged accidents the subject child had and the mother's failure to provide medical documentation. There was also a history of the family having inconsistent accounts as to how the subject child received the repeated bruises.

**Legal Reference:**
18 NYCRR 432.1(aa)

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 02/02/2016 | 11427 - Deceased Child, Male, 6 Years | 11429 - Mother's Partner, Male, 42 Years | Inadequate Guardianship | Indicated | Yes |
| | 11427 - Deceased Child, Male, 6 Years | 11428 - Mother, Female, 26 Years | Fractures | Unfounded | |
| | 11427 - Deceased Child, Male, 6 Years | 11428 - Mother, Female, 26 Years | Inadequate Guardianship | Indicated | |
| | 11427 - Deceased Child, Male, 6 Years | 11429 - Mother's Partner, Male, 42 Years | Fractures | Unfounded | |

**Report Summary:**
The SCR registered a report with allegations of Fractures and Inadequate Guardianship of the subject child by the mother and her partner. It was alleged the child was being abused by the subjects as he had a series of suspicious injuries. The

report said in October 2015, the child had a fractured jaw, and a few weeks prior to the report, the child had scratches near his eye. A week prior to the report the child had a tooth “knocked out.” The report stated for all three injuries the mother explained that the subject child fell.

ACS investigated the report and made contact with the child's school. The guidance counselor expressed concerns for the number of “accidents” the child had since September 2015. The guidance counselor said the child had 24 absences since the beginning of the school year, and based on the mother’s reports they were related to accidents the child had outside the school. The guidance counselor noted that the mother would call the school to notify the staff of the subject child’s absences but did not follow up with doctors’ notes. The child’s promotion for the school year beginning 9/16 was also in doubt . ACS did not add the allegation of Educational Neglect of the child by the mother.

On 2/3/16, the Specialist called the mother, who indicated she was on her way to the dentist's office to obtain paperwork concerning the subject child’s accidents. She also confirmed that she had taken the child for medical treatment.

During this contact, the Specialist heard the mother’s partner telling the mother to discontinue the call and contact a lawyer. The mother responded, telling the mother's partner “to stop” because this matter pertained to “her son.” The mother was upset that her partner was listed in the report noting they did not reside together. A visit was scheduled to meet with the mother and child at the shelter on 2/3/16.

Upon arrival at the shelter, ACS documented the family’s unit was neat and clean with adequate provisions for the family and clothes for the child. There were no safety hazards in the unit. The mother informed ACS her partner of approximately 8 months had ended the relationship earlier in the day after learning of the new SCR report. The mother denied anyone was abusing the child and said she would not allow this to happen. The mother said the child was “clumsy and falls a lot.” ACS did not consider this a possible red flag for a referral for medical follow up and did not consider the former partner’s reaction as a possible sign of domestic violence. The mother explained due to her challenging medical condition, it was difficult for her to get up in the mornings to take the child to school. The mother said she had the support of her relatives, but they resided far from her home. After the fatality, ACS learned that the mother had not been in contact with her family for months prior to the death of the child. ACS did not ask the mother for the names or contact information of these relatives. These individuals could have provided more information regarding the mother and her interaction with the family.

There was a discussion about many incidents when the subject child required dental care to address injuries and possible neglect. The mother denied the child had a fracture in October 2015. The mother explained the child fell off his scooter on the steps and hit his mouth; the child’s face was swollen and the dentist took x-rays that revealed he did not have a fracture. The mother said the child had four top teeth extracted when he was 3 years old due to “bottle rot,” and in January 2016 the child fell and two of his bottom teeth were knocked out. No additional details were provided by the mother who showed ACS a note from the dentist which only mentioned the child was seen in January and the care he received. ACS did not obtain HIPAA consent from the mother to contact the dentist.

ACS did not interview mother’s partner who was a subject of the report.

| **Determination:** Indicated | **Date of Determination:** 03/25/2016 |
|---|---|

**Basis for Determination:**

The allegation of Fractures was unsubstantiated for both subjects because the subject child was assessed by "a medical professional" and it was determined that the child did not have a fractured jaw. This information was provided by the mother. ACS did not make a collateral contact with the medical professional to verify this information or the alleged fracture that reportedly occurred in October 2015. ACS substantiated the allegation of Inadequate Guardianship against both subjects. ACS based this decision on the subject child's account which noted that the mother and mother's partner

were sitting on a bench talking while in the park when the child fell and hurt himself to the extent he required medical intervention. ACS further documented the adullts did not provide adequate care of the child which resulted in the child being physically harmed by another child.

**OCFS Review Results:**
On 3/25/16, the Specialist submitted the report for closure although the directives provided by the manager were not addressed. There were missing collateral contacts with relatives, police, medical personnel, inadequate interviews, and no interview with the mother's partner who was a subject of the report. ACS also did not complete the ACS protocols for domestic violence and substance abuse screening. ACS did not consider adding the allegation of Lack of Supervision of the child by the mother and her partner, or the allegation of Educational Neglect of the child by the mother. The Safety Assessment completed at the investigation determination did not contain updated information and parts were copied and pasted from the 7-day Safety Assessment. There were inaccuracies noted in the Investigation Actions report as the Child Protective Specialist indicated an interview was conducted with all subjects. This report was approved by the supervisor.

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

**Issue:**
Failure to provide notice of report
**Summary:**
ACS made no effort to contact the subject child's father and no Notice of Existence of a Report was issued for him.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Failure to Provide Notice of Indication
**Summary:**
ACS made no efforts to contact the subject child's father; therefore, no Notice Of Indication was issued for him.
**Legal Reference:**
18 NYCRR 432.2(f)(3)(xi)
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Face-to-Face Interview (Subject/Family)
**Summary:**
ACS failed to interview the mother's partner who was a subject in this report.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(a)
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**

Overall Completeness and Adequacy of Investigation

**Summary:**

On 3/25/16, the Specialist submitted the report for closure although directives provided by the manager were not addressed. There were missing collateral contacts, inadequate interviews, and no interview with the mother's partner who was a subject of the report. ACS also did not complete the relevant protocols. ACS was not in compliance with case closing standard.

**Legal Reference:**

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

**Action:**

ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action 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 failed to contact relevant family members and/or service providers to obtain information necessary to determine and respond to safety and risk concerns or salient family needs and to monitor the emergence or presence of safety factors. The Safety Assessment completed at the investigation determination did not contain updated information and parts were copied and pasted from the 7-day safety assessment. The Risk Assessment Profile was also inaccurate in some sections and incomplete in others, for example, ACS documented that the family had stable housing and had reliable supports.

**Legal Reference:**

18 NYCRR 432.1(aa)

**Action:**

ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action 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 made determinations of allegations concerning the mother's partner without interviewing him. ACS unsubstantiated the allegation of Fractures by both subjects without accurately exploring the allegation. This determination was based solely on the information provided by the mother as there was no collateral contact concerning the alleged fracture that reportedly occurred in October 2015. ACS did not consider adding the allegation of Lack of Supervision of the child by the mother and her partner. ACS made determination of the allegations without conducting a thorough investigation.

**Legal Reference:**

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

**Action:**

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

**Issue:**

Contact/Information From Reporting/Collateral Source

**Summary:**

ACS failed to contact relevant collaterals to obtain information necessary to determine and respond to safety and or risk

concerns or salient family needs and to monitor the emergence or presence of safety factors. Specifically, the Specialist did not make the appropriate collateral contacts with the child's primary care physician or dentist.

**Legal Reference:**

18 NYCRR 432.2(b)(3)(ii)(b)

**Action:**

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 08/31/2015 | 11424 - Deceased Child, Male, 6 Years | 11426 - Mother's Partner, Male, 42 Years | Inadequate Guardianship | Indicated | Yes |
| | 11424 - Deceased Child, Male, 6 Years | 11425 - Mother, Female, 26 Years | Inadequate Guardianship | Indicated | |

**Report Summary:**

The SCR registered a report with allegations of Inadequate Guardianship of the subject child by the mother and her partner, and Excessive Corporal Punishment of the subject child by the mother. The report alleged that on 8/31/15 at about 8:00 pm, for unknown reasons in the presence of the subject child, the mother and the mother's partner physically assaulted another resident in the shelter.

On 8/31/15, ACS' Emergency Children's Services attempted to visit the family at the shelter and was informed the mother was arrested and the whereabouts of the child were unknown. There was no inquiry about the incident or attempt to speak to the other party involved in the alleged altercation. In addition, Emergency Children's Services did not contact the local precinct to explore the whereabouts of the child and did not conduct a clearance to obtain the address of the mother's partner. This was imperative as ACS noted there was "immediate concern" regarding the safety of the subject child. ACS learned the family continued to reside at the same shelter and the mother continued to be with the partner.

The record reflects the family and the mother's partner were interviewed at the Manhattan Field Office on 9/1/15. The child was asked about the methods of discipline used and he reported that when he misbehaved he was "beaten" with a belt by his mother's partner. The child said "it hurt," but he "does not cry." The Specialist documented that the child "went back and forth about being put in the shower" by the mother's partner when he misbehaved. The frequency of these incidents and/or visits to the partner's home was not explored. There were no attempts to visit the partner's home for assessment; there was no effort made to conduct a full body check of the child after he made the disclosure he was hit and to determine if there were any marks or bruises.

The subject child gave a detailed description of the altercation reported to the SCR involving the mother, her partner and another resident from the shelter, who the child referred to as "the girl." The child said he saw the police take his mother away. The record did not reflect that the child was asked where he went with the mother's partner after the mother was taken into police custody or where he slept on the day of the incident. Later, ACS was informed by the shelter staff that there was an incident that occurred days prior to the SCR report where the mother allegedly left the child with a stranger by the park. The child reported that he stayed with the "old lady and the old man" and the man took him to the store. The child also said the "girl with the black hair" took him." There was no report made to the SCR regarding this incident.

The mother's partner denied the allegations of the report and denied placing the child in a cold shower as a form of discipline. He said he had no challenges with parenting; however, ACS did not ask him about the child's disclosure of

being hit with a belt. The mother was interviewed and corroborated her partner's accounts.

Between 9/2/15 and 9/21/15, ACS had no contact with the family. On 9/2/15, the Supervisor directed the Specialist to contact the subject child's father, the mother's family and to conduct a screen for domestic violence; none of this was done and the case was closed before the 60 days provided for the investigation of reports. There was no documentation reflecting that the questions from the DV protocol were asked of either adult in the home. The documentation only reflected the mother's denial of DV.

On 9/8/15, ACS received the results of the Domestic Incident Report clearances and learned that mother's partner was involved in 4 reported incidents, 3 of which involved another female. There was no documentation to determine that ACS followed up with the female named in the reports to determine the level of involvement with the family or if there were any children in that home to assess their safety.

| **Determination:** Indicated | **Date of Determination:** 10/02/2015 |
|---|---|

**Basis for Determination:**
ACS substantiated the allegations against the mother based on her involvement in two physical altercations with another resident in the shelter in the presence of the subject child. The mother was arrested and charged with Assault and Attempted Assault. ACS cited that the mother's partner failed to intervene to stop the altercation and instead participated in the incident. ACS also noted that the mother's partner failed to remove the subject child from the incident. The case documentation did not reflect if the child was injured during these incidents.

**OCFS Review Results:**
ACS investigated the report but did not complete a thorough exploration of the issues around possible domestic violence or the methods of discipline used by the adults. This was not a thorough investigation as again there were no attempts to locate or notify the child's biological father, and no collateral contacts made to assess the family or the safety of the subject child. ACS did not add or explore the allegation of Excessive Corporal Punishment although the child disclosed the methods of discipline used by the adults. There was a lack of supervisory guidance to ensure that the Specialist conducted a thorough investigation of the allegations and the underlying factors affecting the family. ACS again recognized the concerns involving the mother's clinical, medical, and substance abuse history but failed to request that the mother sign a HIPAA release to allow access to the information.

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

**Issue:**
Timely/Adequate Seven Day Assessment

**Summary:**
The information documented in the safety assessment was inconsistent as ACS completed the 7-Day Safety Assessment and noted that safety factors were present but did not rise to the level of immediate or impending danger of serious harm. To support the safety decision ACS selected safety factors and noted that based on the mother's prior history she was unable or unwilling to protect the subject child, the mother's medical or mental health or developmental issues negatively impacted her ability to supervise protect and/or care for the subject child, and that the mother was unable or unwilling to meet the subject child's needs of clothing, shelter or medical and mental health. ACS also noted that the mother and the mother's partner were unable to control the subject child's behavior and as a result the mother's partner was using excessive corporal punishment as a form of discipline. The information documented in the safety assessment was not supported in the progress notes as there was no documentation and/or collateral contacts to verify information concerning the mother medical and/or clinical former/current services or the subject child's ongoing medical care. In addition, there was inaccurate information documented in the safety assessment such as: referenced to the subject child having a positive toxicology and the mother having two unfounded reports.

**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

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

**Issue:**
Adequacy of Progress Notes
**Summary:**
ACS documented the interviews with the shelter staff, the subjects and the subject child verbatim and there was no clarity as to what occurred during the reported incidents involving the physical altercations of the subjects with a shelter resident in the presence of the subject child.
**Legal Reference:**
18 NYCRR 428.5
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Contact/Information From Reporting/Collateral Source
**Summary:**
ACS made no attempts to locate or notify the subject child's biological father, and there were no collateral contacts made to assess the family or the safety of the subject child.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(b)
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Failure to provide notice of report
**Summary:**
ACS did not consider consulting with Family Court Legal Services for at minimum, court ordered supervision of the family.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Overall Completeness and Adequacy of Investigation
**Summary:**
This was not a thorough investigation as there were no attempts to locate or notify the subject child's biological father, and no collateral contacts made to assess the family or the safety of the subject child. ACS should have added and explored the allegation of Excessive Corporal Punishment as the subject child disclosed the methods of discipline used

by the adults. There was a lack of supervisory guidance to ensure that the Specialist conducted a thorough investigation of the allegations and the underlying factors in the family. ACS recognized the concerns involving the mother's clinical, medical, and substance abuse history but failed to request that the mother sign HIPAA for the medical providers and the former drug program to verify the mother self-reported condition and clinical diagnosis. ACS also acknowledged the mother's poor judgment when making decisions for the subject child and linked this to her mental health. ACS did not specifically address with the mother the previous discussion of the referrals for the mental health services and/or the recommendations made by the Mental Health Clinic.

**Legal Reference:**

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

**Action:**

ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action 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 consider consulting with Family Court Legal Services for at minimum, court ordered supervision of the family.

**Legal Reference:**

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

**Action:**

ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action 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 did not fully explore adding the allegation of Emotional Abuse as it appears the mother and her partner continued to use inappropriate methods of discipline. ACS also did not add the allegation of Excessive Corporal Punishment regarding the subject child's disclosure of the methods used by the mother and her partner.

**Legal Reference:**

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

**Action:**

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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 06/30/2015 | 11420 - Deceased Child, Male, 6 Years | 11422 - Mother's Partner, Male, 41 Years | Inadequate Guardianship | Indicated | Yes |
| | 11420 - Deceased Child, Male, 6 Years | 11423 - Mother, Female, 25 Years | Inadequate Guardianship | Indicated | |
| | 11420 - Deceased Child, | 11423 - Mother, Female, | Excessive Corporal | Unfounded | |

| | | | | |
|---|---|---|---|---|
| | Male, 6 Years | 25 Years | Punishment | |

**Report Summary:**
The SCR registered a report with allegations of Inadequate Guardianship of the subject child by the mother and her partner, and Excessive Corporal Punishment of the child by the mother. The report alleged on 6/30/15, the mother's partner hit the child at least twenty times with excessive force on his buttocks and legs as a method of punishment while at a picnic. The child was allegedly "not listening." It was reported that the mother was present during this incident and failed to protect the child. The mother denied the allegations.

During the investigation, ACS observed the subject child on several occasions in the home and in the Manhattan Field Office and noted that he was free of marks and bruises. Concerning the incident reported to the SCR, the child denied being hit at the park but disclosed that he was hit by the mother's partner at the mother's friend's home. ACS did not explore this information provided by the child and did not probe for information about the mother's friend. The child also reported that the mother's partner "beat him" with a belt on his butt when he misbehaved, and had placed him under a cold shower for misbehaving; the mother slapped him. The child indicated that the mother's partner had him do five push-ups when he misbehaved. The child said he was not afraid of the mother's partner, but then clarified he was afraid when he (the child) did something "bad." The mother refused to provide information about the people who attended the picnic.

During this investigation, the child was not attending school, but was registered to attend kindergarten in September 2015. Initially, the mother did not provide information concerning the child's medical provider. The mother reported she took the child to the emergency room for episodic visits. However, the mother provided medical documentation from a pediatrician in Manhattan who confirmed the child had a physical exam on 7/14/15, his immunizations were up to date and there were no medical concerns. There was no follow up with this medical provider. It appears the child was not still receiving routine medical care.

ACS conducted two interviews with the mother's partner; at a community park and in the Manhattan Field Office. The mother's partner denied the allegations of the report, but contrary to the mother's statement, admitted that he assisted the mother with the discipline of the child. The mother's partner said he would turn on a cold shower and tell the child he would put him in the shower if he "be bad." However, he denied ever placing the child under the cold shower and explained that he used this method of discipline as "leverage" for the child to "behave." When asked what the child did when he "was being bad," the mother's partner hesitated and said that he did not know. He said he really was not present when the child misbehaved, but the mother would tell him what the child did and he would talk to the child and "discipline" him. Some of the behaviors the mother reported to her partner were: the child put his hand in his mother's face and was running around the shelter room when his mother was trying to sleep. The mother's partner said that in order to get the subject child to behave, he would also take the child to the store, show him toys and then tell him he cannot have any of the toys because he is "being bad."

| | |
|---|---|
| **Determination:** Indicated | **Date of Determination:** 08/28/2015 |

**Basis for Determination:**
ACS substantiated the allegation of Inadequate Guardianship against the subjects on the basis of the child's statements that the mother's partner put him naked, in cold showers, as a form of discipline. ACS further documented that his mother was aware of the punishment and even slapped his face while he was in the shower. ACS also documented that the mother's partner admitted he turns on the cold shower and threatened the child "as leverage." ACS unsubstantiated the allegation of Excessive Corporal Punishment of the child by the mother without providing a narrative for the basis of this decision.

**OCFS Review Results:**
ACS did not explore adding the allegation of Emotional Abuse based on the cruel methods of "discipline" reported by the

child and the subjects. This method of "discipline" was excessive and inappropriate. This investigation was not thorough and the documentation was poor. ACS made no collateral contacts for this investigation. ACS had information regarding the mother's relatives, but made no efforts to contact anyone. ACS documented that there was a discussion with the mother and her partner regarding the inappropriate methods of discipline; however, the details were not noted. The Specialist, in a summary note which appeared after the Supervisory review indicating the allegation of Inadequate Guardianship was being substantiated, documented that contact was made with the family shelter's case manager; however, this contact was not reflected in the case documentation. Additionally the Specialist documented that the report was being unfounded due to lack of credible evidence. Ultimately the report was indicated. ACS should have added the allegation of Excessive Corporal Punishment for the mother's partner and substantiated for both subjects.

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

**Issue:**

Predetermination/Assessment of Current Safety and Risk

**Summary:**

At the time ACS completed the determination safety assessment, they had made no collateral contacts to reassess the subject child's safety. Due to the lack of information it was not clear whether this was an appropriate safety decision as this case involved a mother who had a substance abuse history, a medical condition and mental health issues. The information concerning these issues was obtained from the mother; therefore, it is not certain that the clinical diagnosis she provided was correct. The physical impact of her medical condition was not discussed as it pertained to her ability to care for the subject child. Other selected safety factors were similar to those on the 7-day Safety Assessment and were supported with the same comments. The final risk rating on the Risk Assessment Profile was moderate; however, ACS did not properly answer the questions on the form. In addition, some of the information needed (especially for the mother's partner) to complete the Risk Assessment Profile was not gathered throughout the investigation, and questions related to financial resources, familial and other supports, domestic violence, mental health, cognitive skills, physical illnesses, expectations of the subject child, and seriousness of current or potential harm to the subject child were not addressed appropriately.

**Legal Reference:**

18 NYCRR 432.1(aa)

**Action:**

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

**Issue:**

Contact/Information From Reporting/Collateral Source

**Summary:**

ACS did not make any collateral contacts for this investigation. ACS copied and pasted a list of the mother's relatives from the ACS's Automated Case Review System database, but made no efforts to contact anyone. In addition, ACS documented medical, clinical and substance abuse information as reported by the mother, but did not request that the mother sign Health Insurance Portability and Accountability Act forms to confirm or explore the information further to determine whether these issues could present a problem with her ability to care for the subject child.

**Legal Reference:**

18 NYCRR 432.2(b)(3)(ii)(b)

**Action:**

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

**Issue:**
Adequacy of Progress Notes
**Summary:**
The progress notes did not provide details or contain assessments of the information gathered.
**Legal Reference:**
18 NYCRR 428.5
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action 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 the allegation of Inadequate Guardianship against the subjects, but unsubstantiated the allegation of Excessive Corporal Punishment of the subject child by the mother without providing a narrative for the basis of this decision. This allegation should have also been added for the mother's partner and substantiated for both subjects. Based on the description of the subject child's "bad behavior" reported by the subjects and the Specialist's observations, the subject child's behavior was age appropriate. In addition, according to the documentation of the Specialist's observation of the subject child's overall behavior and interaction towards the subjects seemed appropriate. ACS did not explore adding the allegation of Emotional Abuse based on the cruel methods of "discipline" reported by the subject child and the subjects. Considering the subject child's age, this was excessive and inappropriate.
**Legal Reference:**
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

**Issue:**
Overall Completeness and Adequacy of Investigation
**Summary:**
The documentation reflected that throughout the investigation of the 6/30/15 report, the Specialist failed to obtain information necessary to determine and respond to safety and or risk concerns or salient family needs and to monitor the emergence or presence of safety factors. ACS documented the information provided by the subjects verbatim and did not confirm any of the information they provided. In addition, ACS appeared to have allowed the mother to control the investigation when she refused to provide contact information for individuals that were present on the day of the alleged incident, medical providers or relatives. The level of casework activity and supervisory oversight was also inadequate. The investigation of the report was solely allegation focused and failed to contemplate other possible issues or concerns with the family. ACS did not explore adding the allegation of Emotional Abuse based on the cruel methods of "discipline" reported by the subject child and the subjects. Considering the subject child's age, this was excessive and inappropriate.
**Legal Reference:**
SSL 424(6); 18 NYCRR 432.2(b)(3)
**Action:**
ACS must meet with the staff involved in this investigation and inform OCFS of the date of the meeting, who attended, and what was discussed; and submit a corrective action plan within 45 days that identifies what action it has taken or will

take to address this issue.

**Issue:**
Pre-Determination/Nature, Extent and Cause of Any Condition

**Summary:**
ACS substantiated the allegation of Inadequate Guardianship against the subjects, but unsubstantiated the allegation of Excessive Corporal Punishment of the subject child by the mother without providing a narrative for the basis of this decision. This allegation should have also been added for the mother's partner and substantiated for both subjects. Based on the description of the subject child's "bad behavior" reported by the subjects and the Specialist's observations, the subject child's behavior was age appropriate. In addition, according to the documentation of the Specialist's observation of the subject child's overall behavior and interaction towards the subjects seemed appropriate.

**Legal Reference:**
18 NYCRR 432.2(b)(3)(iii)(c)

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

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

On 6/22/10 the SCR registered a report with allegations of Parents' Drug/Alcohol Misuse against the mother of the subject child. The mother tested positive for marijuana after giving birth to the child. However, the child's toxicology report was negative and the medical staff indicated that the mother's use of marijuana did not affect the child in any way. The mother was discharged from the hospital with the subject child and tested negative for marijuana prior to her discharge. The report was unfounded on 8/19/10.

## Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

## Required Action(s)

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

| | |
|---|---|
| **Issue:** | Adequacy of case planning |
| **Summary:** | Case Closing and Case Management:<br>The preventive agency did not meet the standards for Child protective Monitor/Case Manger as established under Improved Outcomes for Children (IOC). That is, the agency did not: see that risk reduction activities and services were being implemented in the established plan for services, modify the service plan when progress was insufficient; see to the sufficiency of the service plan in addressing the health and safety of the child; and see that the service plan addressed long-term risk reduction and the resolution of identified problems that create risk. 18 NYCRR 432.2 (b) (5) |

| | |
|---|---|
| | In addition, the agency failed to utilize the case closing protocols provided by ACS. Although ACS' policy directed that ACS staff were not required to participate in Service Termination Conferences (STC), case documentation did not reflect that the preventive program director and supervisor were participants or provided direction and guidance to the Case Planner around assessments required when closing a 'Protective' services case. The termination of services/case closing did not meet the standards for case closing established in state regulations 18 NYCRR 432.2 (c) (2) to the State Central Register. |
| **Legal Reference:** | 18 NYCRR 432.2 (b)(2) |
| **Action:** | ACS must obtain and submit a corrective action plan from St Luke's preventive services agency 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 OCFS of the date of the meeting, who attended and what was discussed. |
| | |
| **Issue:** | Mandated reporters did not report potential abuse or maltreatment of a child |
| **Summary:** | The preventive services agency failed to report instances of suspected abuse of the child when this was observed. |
| **Legal Reference:** | SSL 413 and 415 |
| **Action:** | ACS must obtain and submit a corrective action plan from St Luke's preventive services agency 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 OCFS of the date of the meeting, who attended and what was discussed. |
| | |

## Preventive Services History

The family was referred to St. Luke's Roosevelt Hospital Center Family Treatment Rehabilitation Program for Preventive Services for assistance with the mother's medical needs, mental health needs, history of substance abuse, and reported recent substance misuse. ACS conducted the required joint home visit with the preventive service agency on 9/24/15. On 9/28/15 the mother signed for services. At that time, she shared that she previously completed a 13 month substance abuse program at Odyssey House due to unspecified drug use.

During the time the preventive case was open, the agency referred the mother for mental health evaluation and drug testing; however, the mother did not comply. The child began therapy at the Child and Family Institute and later with Jewish Board of Family and Children Services; however, these services ended as the family failed to comply with keeping appointments. Additionally at three separate contacts with the family the Case Planner expressed concern about the frequency of the child's physical injuries; however, the Case Planner did not report the injuries to the authorities including the SCR.

The case was closed with concerns which included, the child being "accident prone," issues with his inability to focus in school, the mother's medical condition, and the fact that the family intended to move to Boston.

The management of this case was inadequate. There was no legal intervention or amendment to service plan.

## 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

## Additional Local District Comments

In response to an initial review of the report, ACS made the following comments:

ACS has placed the five workers involved in the investigation on modified duty on 9/30/16 and is pursuing additional disciplinary charges. If any return to case work, ACS will develop corrective actions based on the specifics of this case.

ACS placed St. Luke's on Corrective Action on October 13, 2016.

ACS will hire an independent monitor to review our Child Protective and Preventive Services programs, which will complement the work underway by Casey Family Programs to strengthen child safety practice. ACS will work with OCFS to ensure the objectives for this monitor are being met.

ACS has undertaken thorough audit of cases by the 5 staff involved in the Perkins investigation and is assessing all ACS investigative units, including the Manhattan Field Office, to determine if casework and supervision practice adheres to standards.

## 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

**Explain:** New York State directs ACS to conduct a full evaluation of caseworkers, case supervisors, and borough managers in the Manhattan Borough Office to assess competencies, strengths and weaknesses and take the appropriate action necessary to respond to any identified issues.