Child Fatality Report

Report Identification Number: NY-16-091

Prepared by: New York City Regional Office

Issue Date: Mar 21, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

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 **Jurisdiction:** Kings **Date of Death:** 04/30/2008
Age: 1 year(s) **Gender:** Male **Initial Date OCFS Notified:** 08/26/2016

Presenting Information

The 8/26/16 report alleged that 4 years ago, the SM and parental substitute (PS) beat the unknown 4-year-old SC. The SC was beaten so severely that he had broken bones, and died from blunt force trauma. The SM was very angry, violent and out of control. The SM smoked marijuana while caring for the 3-year-old male child and 1-year-old female child. When the SM smoked marijuana she became even more violent and out of control. The SM kicked and hit the 3-year-old child with a belt and her hand, which had resulted in bruises to the 3-year-old child in the past. The SM screamed at the 3-year-old child on a regular basis. The SM prostituted from the home. She allowed random people off the street to come in and babysit for the 3-year and 1-year-old children.

The subsequent report of 9/30/16 alleged that on 4/30/08, the SF hit the 1-year-old child causing him to hit a dresser and fall to the floor, hitting his head. There were no known visible injuries. The SC died as a result.

Executive Summary

The 16-month-old male child (SC) died on 4/30/08. The autopsy listed the cause of death as a concussive brain injury due to blunt impact to the head and the manner of death as an accident.

The allegations of the 8/26/16 report were DOA/Fatality, IG, and FX of the SC by the SM and PS, and IG, PD/AM, and L/B/W of the 3-year-old male half sibling (HS), and IG and PD/AM by the 1-year-old female HS by the SM. The allegations of the 9/30/16 report were DOA/Fatality and IG of the SC by the SF.

The SCR had registered a report concerning the SC's death on 4/30/08. OCFS issued fatality report 95-08-033 pertaining to the fatality. ACS addressed the citations of not providing any information in the Investigation Conclusion Narrative for the allegation of PD/AM during the 10/10/07 investigation and the failure to complete the determination of the 4/30/08 report within the required 60-day timeframe.

Regarding the 8/26/16 report, ACS was informed by the SM on 9/29/16, that in June 2008 the SF stated he only hit the SC once, and that was when the SC hit the dresser, fell on the floor and hit his head. The SM said this was the cause of the SC's death. Later, the SM said that when the SC passed she was at the hospital ER with the now 9-year-old sibling. Prior to leaving for the hospital, she and the SF had an argument. The SM said she was at the hospital while the SF was home with the SC. When she returned to the home, the SF was putting the SC in the crib. The SM said she asked the SF what happened and the SF said the SC would not listen. The SM looked at the SC and he seemed unusual. She took him out of the crib and began CPR. SM said that in April 2008 she told LE the SC was jumping on the bed as that was what the SF had told her. She stated that on 6/24/08, the SF told her about the incident concerning the SC's death. The SM said the SF told her the SC would not listen and he did not know what to do. She said he stated he was going to beat the SC but he only hit him once. The SC was on the bed when he slapped him, and he went into the dresser and fell to the ground. The SM said she became angry and asked SF why he hit the SC. The SF began to beat her and he put a knife to her throat and then to his wrist. SM said the SF told her he wanted her to get marijuana for him.

On 10/25/16, ACS Sub the allegations of DOA/Fatality and IG of the 8/26/16 report by the SM on the basis that the

SM said she was in the home with the SC when the fatality occurred. SM noted that two months after the SC passed away the SF told her he hit the SC causing him to hit his head, and subsequently die. SM did not disclose this information to anyone causing the SC's death to not be properly investigated. ACS Unsub the allegations of FX, IG, PD/AM, and L/B/W. During the investigation, there was no mention of fractures for the SC. ACS did not obtain credible evidence to corroborate the SM's drug or alcohol use while being the sole caretaker for the children. ACS did not observe drugs or alcohol in the home during the visits. The SM submitted to a drug screen and the result was negative for illicit drugs. The children were observed to be properly supervised in the home. ACS did not observe marks or bruises on the 3-year-old HS. ACS obtained information from several collateral contacts and found the children did not have marks/bruises and the SM did not appear to use corporal punishment on the child.

The allegations of DOA/Fatality, FX, and IG of the SC by the PS was Unsub. ACS based the determination on the finding that the PS did not have contact with the SC. The SC passed away before the PS and SM began their relationship. The PS did not reside in the home with the children. The PS was incarcerated on 8/25/16 before the ACS investigation began.

On 11/29/16, ACS Unsub the allegations of DOA/Fatality and IG of the SC by the SF (for the 9/30/16 report) on the basis that the SC died 8 years ago and his cause of death was ruled accidental.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
N/A

Was the decision to close the case appropriate?	N/A
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:
NA

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24-Hour safety assessment for the 8/26/16 report was inadequate as ACS did not identify the safety factors that actually placed the children in immediate danger. The 24-Hour safety assessment for the 9/30/16 report was completed on 10/3/16.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	During the 8/26/16 investigation, ACS did not interview the parental substitute who was a subject of the report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	ACS must submit a corrective action plan 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:	During the 9/30/16 investigation, the 7-Day safety assessment was not completed timely as it was completed on 10/28/16. The safety decision selected was inadequate as no safety factors were identified although the SS had remained in foster care.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	During the 9/30/16 investigation, the 11/25/16 safety assessment was inadequate as the selected safety decision reflected there was no safety factors that placed the SS in immediate danger. The SS had remained in foster care placement.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS must submit a corrective action plan 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:	Appropriateness of allegation determination
Summary:	During the 9/30/16 investigation, ACS inappropriately Unsub the allegations of DOA/Fatality and IG by the SF. ACS must apply the legal elements of maltreatment and the causal relationship between

	the death and the parent's actions/inactions.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a corrective action plan 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:	Failure to Provide Notice of Indication
Summary:	The CONNECTIONS Event List reflected that during the 8/26/16 investigation, ACS did not provide the subjects, the SM and PS, the Notice of Indication (NOI) until 12/1/16. The NOI was not provided within 7 days of the conclusion of the investigation.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must submit a corrective action plan 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: 04/30/2008 **Time of Death:** 02:00 PM

Time of fatal incident, if different than time of death: 12:48 PM

County where fatality incident occurred: KINGS
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: child was jumping on the bed

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality				
Household	**Relationship**	**Role**	**Gender**	**Age**
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Other Household 1	Other Adult	Alleged Perpetrator	Male	36 Year(s)
Other Household 2	Mother	Alleged Perpetrator	Female	29 Year(s)
Other Household 2	Sibling	Alleged Victim	Female	1 Year(s)
Other Household 2	Sibling	Alleged Victim	Male	3 Year(s)
Other Household 3	Sibling	No Role	Female	9 Year(s)
Other Household 4	Father	Alleged Perpetrator	Male	33 Year(s)
Other Household 4	Sibling	No Role	Female	3 Year(s)
Other Household 5	Sibling	No Role	Female	5 Year(s)

LDSS Response

On 8/26/16, ACS interviewed a neighbor who said the SM disclosed to her that she and her PS beat her child so bad it resulted in him passing away. The neighbor said she and the SM were no longer friends. She said she observed on many occasions the SM cursed the 3-year-old HS and spoke to him as if he were an adult. She said she saw the SM hit the 3-year-old with her hand, a belt and she kicked him. On a regular basis she saw the SM stand in the hallway cursing at the 3-year-old child. Documentation of the interview did not indicate what the SM's actions were in response to. The neighbor said she believed the children should not be in the SM’s care. She also stated that in the past she saw marks and bruises on the children.

On 8/26/16, the SM said the SF killed the SC. SM added that she had not observed the 9-year-old SS since February 2016. She said ACS and the Family Court were trying to terminate her parental rights. SM said she was involved in an appeal. She said there was also a case against her for the 3-year-old child. The case was closed due to her meeting and completing all her goals. The SM denied ever telling anyone that she had beaten her child to death. She informed ACS that her children received adequate care and she denied prostituting herself. The SM said she disciplined her child by telling him no and taking away his privileges when he did not listen. The 3-year-old and 1-year-old children were observed. The 3-year-old child denied that the SM hit or kicked him. He said he had not seen the SM smoke in the home. No marks or bruises were observed on either child during the visit. Documentation reflected ACS received the criminal history and domestic incident reports (DIR) for the family.

On 9/30/16, ACS spoke with an assigned Family Court Legal Service (FCLS) attorney who said the information was of concern as there was a Permanency Hearing scheduled for 11/3/16 and for visitation by the SF. The SF only had supervised visitation at the agency with the SC and he had not been visiting the SC. The SM’s parental rights were terminated. The FCLS attorney said he sent written messages to ascertain if an immediate investigation regarding what, if anything, happened to the SC would have to be done.

On 10/4/16, ACS interviewed the SF who said the SM was trying to reunite their relationship. He said if he had killed the SC and admitted to the SM he did what woman in their right mind would reunite the relationship. Regarding the 4/30/08 investigation, the SF said he was getting ready for work and the SC finished eating and was jumping on the bed. While in the same room as the SC, he heard a thump and thought it was the SC’s sneaker. He turned around and saw the SC on the floor non-responsive. He picked him up and saw food around his mouth; he cleared the area. He and the SM performed

CPR and they called 911. The 3-year-old female HS was observed by ACS. The SF said he went to Family Court to obtain custody of the 3-year-old HS. The SF also had a 5-year-old female child who resided with her mother; the child visited his home. The ACS case record reflected the SF was caring for the 3-year-old with court ordered supervision.

On 10/5/16, LE staff informed ACS staff he was assigned to the case eight years ago when the SC passed away and the SM did not state the SF was responsible for the SC's death. LE recalled the case as they were auto taped by the DA's office during the interviews. LE said the SM was at home at the time the SC passed away. LE said the SF showed text messages between him and the SM. LE reported there were pictures of them talking about the 9-year-old SS who was in foster care placement. LE had interviewed the PGM twice since the 8/26/16 investigation and she sent him e-mails denying the claim that she called the SM stating that she was sorry the SF killed the SC. LE said the SM was found not credible; the SF was cooperative and had not objected to being interviewed.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No
Comments: The investigation adhered to previously approved protocols for joint investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
035525 - Deceased Child, Male, 1 Yrs	035527 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
035525 - Deceased Child, Male, 1 Yrs	035527 - Mother, Female, 29 Year(s)	Fractures	Unsubstantiated
035525 - Deceased Child, Male, 1 Yrs	035527 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
035525 - Deceased Child, Male, 1 Yrs	035526 - Other Adult - Parental Substitute, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
035525 - Deceased Child, Male, 1 Yrs	035526 - Other Adult - Parental Substitute, Male, 36 Year(s)	Fractures	Unsubstantiated
035525 - Deceased Child, Male, 1 Yrs	035531 - Father, Male, 33 Year(s)	Inadequate Guardianship	Unsubstantiated
035525 - Deceased Child, Male, 1 Yrs	035531 - Father, Male, 33 Year(s)	DOA / Fatality	Unsubstantiated

035525 - Deceased Child, Male, 1 Yrs	035526 - Other Adult - Parental Substitute, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
035528 - Sibling, Female, 1 Year(s)	035527 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
035528 - Sibling, Female, 1 Year(s)	035527 - Mother, Female, 29 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
035529 - Sibling, Male, 3 Year(s)	035527 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
035529 - Sibling, Male, 3 Year(s)	035527 - Mother, Female, 29 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
035529 - Sibling, Male, 3 Year(s)	035527 - Mother, Female, 29 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

ACS did not interview the PS who was a subject of the 8/26/16 report and did not interview the other family member who was named in the 9/30/16 report.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine

Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☒	☐	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☐	☒	☐	☐

Explain as necessary:
The SC died on 4/30/08. The SC's sibling who was then an 8-month-old infant was placed into protective custody by ACS. On 5/19/08, ACS filed an Article Ten Neglect petition in the Kings County Family Court (KCFS) naming the parents as the respondents.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?
☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/19/2008	Adjudicated Neglected	Foster Care Placement to Continue
Respondent:	035527 Mother Female 29 Year(s)	
Comments:	ACS filed an Article Ten Neglect petition in KCFC on behalf of the SC (deceased) and SS naming the SM and SF as the respondents on 5/19/08. The KCFC granted ACS a remand of the SS (who was then 8-months old) citing reasonable efforts were made to prevent the placement. The court denied the parents' request for unsupervised liberal visits with the child. ACS documentation reflected that a termination of parental rights (TPR) was filed against the SM in March 2011. The SF was in and out of jail. In July 2011, the SM voluntarily surrendered her parental rights. This was appealed and the SM lost the appeal on 7/21/11. The 11/14/16 FASP reflected the SM's parental rights were terminated on 8/3/16. The SF had since come forward again and wanted to plan for the SS. The SF had visited sporadically since May 2016 when he appeared at a court hearing, and attributed the missed visits to his work schedule. The case record did not include details of the SF's proof of employment.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/05/2012	There was not a fact finding	Adjourned in Contemplation of Dismissal (ACD)
Respondent:	035527 Mother Female 29 Year(s)	
Comments:	On 9/4/12, ACS removed the female half sibling (who was then an infant) from the hospital. On 9/5/12, ACS filed an Article Ten Neglect petition in KCFC naming the SM as the respondent. On 9/14/12, the infant was released to the SM's care with COS. On 4/25/13, a court hearing occurred and the case was adjourned in contemplation of dismissal (ACD).	

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
ACS arranged for services for the SM. These services included DV counseling, referrals for DV shelter, random drug testing and bereavement counseling. ACS also arranged for batterers counseling for the SF. The documentation in the 9/30/16 investigation showed that the 3-year-old child and SF received PPRS.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The 9-year-old SS was placed in foster care.

The FSPN reflected the SM, 3-year-old and 1-year-old half siblings were referred by ACS to address the loss of the SC. ACS referred the family to Jewish Child Care Association (JCCA) Child Parent Psychotherapy (CPP) program to address child behavioral the exposure to the family trauma concerns. The family accepted PPRS with JCCA on 11/7/16.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCFS report 95-08-033 reflected ACS arranged for services for the SM. These services included DV counseling, referrals for DV shelter, random drug testing and bereavement counseling. ACS also arranged for batterer's counseling

for the SF.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
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)
03/17/2016	14362 - Sibling, Female, 3 Years	14361 - Father, Male, 33 Years	Inadequate Guardianship	Unfounded	Yes
	14362 - Sibling, Female, 3 Years	14361 - Father, Male, 33 Years	Lack of Medical Care	Unfounded	

Report Summary:
The 3/17/16 report alleged the SF had failed to follow through with court ordered services. The SF failed to attend parenting classes, substance abuse, anger management, and domestic violence counseling. The 3-year-old child was developmentally delayed and did not speak. The SF was supposed to have the child evaluated; however, he failed to do so. There was no food in the home.

Determination: Unfounded | **Date of Determination:** 05/16/2016

Basis for Determination:
ACS Unsub the allegations on the basis of finding of no credible evidence. ACS noted there was adequate food, clothes, sleeping arrangements, including clean bedding for the child and proper ventilation in her bedroom. The child was attending daycare. The child's school indicated that the SF signed the child up for services in October 2015 to address her needs. The issue was that the service provider was back logged; however, the child was scheduled to receive services. The SF initiated Early Intervention Services for the child. The child received her well-child check-up with her Dr. The SF completed his service for anger management, parenting skills and grief counseling.

OCFS Review Results:
On 3/18/16, ACS staff visited the home and informed the SF that ACS was there to conduct a protective removal of the 3-year-old child due to a court order. ACS contacted the SF's psychotherapy and training consultant agency and verified the SF met his treatment goals in the program. His treatment focused on anger management, parenting skills and grief counseling. On 3/18/16, ACS was granted a remand of the child from the SF and her mother. A neglect petition was filed against this child's mother for a newborn sibling, but upon ACS review of the history it was learned the SF failed to complete mandated services that were ordered in a prior disposition hearing in 2013.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
ACS documentation was not entered contemporaneously as there were events that occurred in March 2016, but were not entered until May 2016. ACS did not enter these events within the required 30-day timeframe.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/19/2013	14352 - Sibling, Female, 11 Months	14353 - Mother, Female, 21 Years	Inadequate Guardianship	Indicated	Yes
	14352 - Sibling, Female, 11 Months	14351 - Father, Male, 30 Years	Lack of Medical Care	Unfounded	
	14352 - Sibling, Female, 11 Months	14353 - Mother, Female, 21 Years	Lack of Medical Care	Indicated	

Report Summary:
The female half sibling's mother had lost custody of another child in another state. This mother was neglecting the female half sibling (who was then an 11 months old infant). The infant had rashes and scabies all over her body. The mother failed to seek medical care. The infant was in discomfort, and crying all the time. The mother and infant were bouncing from home to home, as she did not have any stable place to reside. The mother was not providing adequate food for the infant, as she only gave the infant cereal and water.

Determination: Indicated | **Date of Determination:** 10/17/2013

Basis for Determination:
ACS noted that the care being provided to the half sibling failed to meet a reasonable minimum standard of care for the child within commonly accepted societal norms. The care provided to the half sibling resulted in actual physical harm to the child and there was imminent danger of such harm. The ACS Specialist was not shown any documentation that the child had her immunizations, and therefore causing the mother to lose her benefits for the child. The Specialist was not shown that the child received follow up medical treatment after receiving a coffee burn. The documentation was not observed to verify that the child was properly treated for her medical condition and was healthy.

OCFS Review Results:
ACS initiated the investigation in a timely manner. ACS added to the 8/19/13 report the allegation of LMC of the child by the SF and mother. ACS completed safety assessments on 8/26/13 and 10/17/13, and a safety modification on 10/17/13. The documentation reflected that the mother did not have stable housing during the investigation. The CPS Investigation Summary reflected an Administrative Review (AR) was requested on 9/14/16. The allegations of IG and LMC by the mother were Sub . The findings as a result of the AR was the allegation of LMC by the SF was Unsub. The AR decision was "Amend the Record." ACS opened a Family Service Stage on 10/1/13 and closed it on 12/12/13.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
In the safety assessments and safety modification documents, ACS inappropriately included comments that did not

support the selected safety factors. ACS listed the safety factor that stated "the child has significant vulnerability, is developmentally delayed, or medical fragile and the parent/caretaker is unable and/or unwilling to provide adequate care and/or protection of the child."

Legal Reference:

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

Action:

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

In the safety assessments and safety modification documents inappropriately included a comments that did not support the selected safety factor. ACS identified the safety factor that stated "the child has a significant vulnerability, is developmentally delayed, or medical fragile and the parent/caretaker is unable and/or unwilling to provide adequate care and/or protection of the child."

Legal Reference:

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

Action:

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

Issue:

Face-to-Face Interview (Subject/Family)

Summary:

The documentation reflected ACS spoke with the SF but did not interview him regarding the allegations. The SF was a subject of the report.

Legal Reference:

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

Action:

ACS must submit a corrective action plan 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

The SM and SF were known to the SCR and ACS as subjects in reports registered on 5/11/07, 10/10/07, and 4/30/08. The SM was also known to the SCR and ACS as a subject in reports dated 8/31/12 and 10/26/12; the SF in report dated 7/2/10. The allegations of the 5/11/07 report were IG of the SC by the parents. On 7/10/07, the report was UNF. The allegations of the 10/10/07 report were PD/AM and IG of the now 9-year-old SS. On 12/11/07, ACS Sub the allegation of IG by the parents and Sub the allegation of PD/AM against the SM. The allegations of the 4/30/08 report were DOA/Fatality, IG, and LS of the then 16-month-old SC, and IG of the then 8-month-old infant by the parents. ACS completed the required risk assessments and also completed safety assessments on 5/19/08, 6/17/08, 8/4/08, and 10/1/08. On 10/1/08, ACS Sub the allegations.

The allegations of the 7/2/10 report were IG and SA of a foster child by the SF and IG by two adults whose role was listed as "Other." On 8/26/10, ACS Sub the allegations of IG and SA by the SF and Unsub the allegations of IG by the two adults. The allegations of the 8/31/12 report were IG of the now 3-year-old half sibling by the SM. On 10/4/12, ACS IND the report. The allegations of the 10/26/12 report were IG of the now 3-year-old half sibling by the SM. ACS completed the required risk assessments. ACS completed safety assessments on 11/1/12 and 12/5/12. The report was IND.

The PS was not known to the SCR or ACS as a subject.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 10/17/2007

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 10/17/2007

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

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

Family Assessment and Service Plan (FASP)

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

Closing

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

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

Additional information, if necessary:
ACS referred the family for PPRS with the Mercy First agency beginning January 2008. Between September 2012 and 5/19/14, the family received Court Ordered Supervision services for the male half sibling. The male half sibling had been released to the SM with adjournment in contemplation of dismissal with 12 months of ACS supervision until 4/25/14.

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 documentation reflected that the Seaman's Society for Children and Family Service agency progress notes were not entered contemporaneously. An event that occurred on 4/18/16 but not entered until 7/5/16.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Preventive Services History

During the investigation of the 10/12/07 report, ACS found the parents did not make appropriate plans for the child (deceased) and SS. ACS provided Family Preservation program intervention services to the family until March 2008. The family received PPRS under the supervision of the Mercy First agency.

Between September 2012 and 5/19/14, the family received Court Ordered Supervision services for the male half sibling. The male half sibling had been released to the SM with adjournment in contemplation of dismissal with 12 months of ACS supervision until 4/25/14. The SM received services to alleviate stress and feelings of being overwhelmed to prevent her from returning to drug use. The SM did not attend therapy consistently nor comply with drug treatment attendance. The SM did not have permanent housing. She received temporary housing services through DV shelter programs.

Following discharge from foster care, the female half sibling received Court Ordered Services under the supervision of the Seamen’s Society for Children (SSC) agency. The female half sibling resided with the BF in the PGM’s home. This half sibling received evaluation and was diagnosed with developmental disabilities. The SSC staff appropriately monitored the home conditions, monitored sibling visits at the agency and observed this half sibling in her pre-school placement.

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The Catholic Guardian Society Family Service Progress Notes reflected that notes were not entered contemporaneously. An event occurred on 10/22/13 but was not entered until 1/13/14.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Adequacy of case recording in FASP
Summary:	The 11/14/13 ACS FASP reflected that the safety assessment was inadequate as the safety factors were not identified to support the decision that the children had been in immediate or impending danger of serious harm.
Legal Reference:	18 NYCRR 428.6(a)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Adequacy of case recording in FASP
Summary:	The 5/14/14 ACS FASP reflected that the safety assessment was inadequate as ACS did not identify the safety factors that actually placed the children in immediate danger.
Legal Reference:	18 NYCRR 428.6(a)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Foster Care Placement History

ACS conducted a protective removal of the SS from the parents' home on 5/17/08. ACS placed the SS in the kinship foster home of the maternal great grandmother (MGGM) who was a licensed foster parent with the Catholic Guardian Society. ACS filed an Article Ten Neglect petition in KCFC and the sibling was remanded to the Commissioner of ACS. The BM voluntarily filed to surrender her parental rights in July 2011. The MGGM was ill in September 2012. The MA temporarily supervised the SS until the SS was transferred to a non-kinship foster care home on 10/12/12.

The SM gave birth to the male half sibling in August 2012. ACS requested a remand of this half sibling on 9/5/12. ACS alleged the SM had not been in contact with the agency for one year and the SM had not been planning for the sibling. The

KCFC remanded the male half sibling to the care of ACS. The male half sibling remained in care until 9/14/12 when he was returned to his parents.

ACS noted the SS was freed for adoption: the ACS case record did not include the timeline. The BF was granted supervised visitation with the SS. As of 1/25/17, the SF continued to attend family visits with the SS. The female half sibling from the BF's other relationship was placed in foster care on 3/20/16 under an Article Ten Neglect petition filed in Queens County Family Court. She was discharged to her parent with COS in March 2016.

Legal History Within Three Years Prior to the Fatality

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

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/12/2007	There was not a fact finding	There was not a disposition
Respondent:	035527 Mother Female 29 Year(s)	
Comments:	ACS filed an Article Ten Neglect petition in Kings County Family Court (KCFC) naming the parents as the respondents. The petition was filed to seek court ordered supervision (COS) of the family. The court granted the request and the two children (the now deceased child and sibling) were returned to the parents.	

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