Child Fatality Report

Report Identification Number: NY-19-065

Prepared by: New York City Regional Office

Issue Date: Dec 06, 2019

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Child Fatality Report

Case Information

Report Type: Child Not Found
Age: Unknown
Jurisdiction: Kings
Gender: Female
Date of Death: Unknown
Initial Date OCFS Notified: 06/11/2019

Presenting Information

The narrative of the SCR report dated 6/11/19, alleged that when the SM was under the influence of heroin, she became angry and out of control towards the twelve and the nine-year-old children. The SM tied both children to their beds and repeatedly whipped them with a leather whip. As a result, the children sustained welts all over their backsides. The SM continued to whip the nine-year-old more than 50 times, she stopped breathing and died. The SM has a history of becoming physically aggressive and violent when under the influence.

Executive Summary

ACS conducted a visit to the case address on 6/13/19, and met with the occupants. The occupants were a male and female couple, both were in their late 60's and had been living at the case address since 1982. The Specialist completed an assessment of the two-bedroom apartment and found no signs or indication that any children resided in the home.

On 6/13/19, ACS sent correspondence via mail to various agencies in an effort to locate the family. On 6/24/19, ACS received the results from the New York City Board of Elections, Department of Probation, Corrections, New York State of Office of Children & Family Service Putative Father Registry in addition to the Coler-Goldwater Specialty Hospital and Nursing Facility. The results from the respective agencies reflected no records were found for any of the reported household members.

On 6/13/19, ACS contacted the Brooklyn District Attorney's Office and the assigned DA reported they are very familiar with this report and informed ACS that past reports had been made in reference to the children and family named in the 6/11/19 report and deemed the family non-existent.

On 7/2/19, ACS received the results of the search request from the National Personnel Records Center, Harlem Hospital Center, Air Force Personnel Center, Kings County Hospital, NYS Department of Motor Vehicles, Bureau of Naval Personnel and the Department of Defense. The results from the respective agencies reflected no records were found for the reported household members.

As of 7/9/19, the family listed on the SCR report was found to be non-existent. ACS completed a diligent search prior to closing the case. On 7/31/19 ACS unsubstantiated all of the allegations of the report and unfounded and legally sealed the case.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:

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Was the decision to close the case appropriate? Yes

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

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

Explain:

The entire family named in the report was not located.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	10 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	64 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)

LDSS Response

The narrative of the SCR report dated 6/11/19, alleged that when the SM was under the influence of heroin, she became angry and out of control towards the twelve and the nine-year-old children. The SM tied both children to their beds and repeatedly whipped them with a leather whip. As a result, the children sustained welts all over their backsides. The SM continued to whip the nine-year-old more than 50 times, she stopped breathing and died. The SM has a history of becoming physically aggressive and violent when under the influence. There is also an eleven-year-old child with an unknown role.

The allegations of this report were DOA/Fatality of the nine-year-old (ten years old at the time of the report), IG, LBW and PD/AM of the twelve and the ten-year-old children by the SM.

ACS' Instant Response Team Coordinators visited the case address and reported there was no sign of the family or any children. The neighbors reported no children ever resided in that apartment. The occupants of the apartment expressed frustration because they have been harassed for many years with false reports concerning children in their apartment.

On 6/11/19, the ACS Brooklyn Field Office initiated their investigation by contacting the LE at the local Precinct and was informed that they were not aware of any such case and they were not investigating. Later that day, LE reported they visited the case address and interviewed the tenant who had resided in the apartment from 1982. LE reported their visit resulted in no sign of a deceased child and nothing suspicious.

ACS then contacted the ACS Investigative Consultant (IC). The IC did not locate Domestic Incident Reports (DIR) involving the reported family. ACS' record clearance reflected an SCR report dated 4/17/18 that contained similar information to that of the 6/11/19 SCR report. The narratives and allegations very similar; ACS closed the 4/17/18 on 5/14/18 citing the report appeared false. ACS' criminal clearance on the family bore negative results. Food Stamps and Medicaid for the reported were inactive.

Regarding prior history associated with the case address, ACS located an extensive SCR history from 2008 to present regarding similar allegations for children reported at the case address; in which no such children were ever located. The numerous reports consist of different names and dates of birth for the reported family members at the same address. There had been several different names used for the reported subjects. LE and the DA's office had been involved in the past in the fictitious reports.

On 6/12/19, the ACS Specialist contacted the management office related to the case address and requested a search of all names listed in the reports past and present. A check for primary and additional family members was completed and yielded no results in their record system.

The Specialist completed the 24-hour Safety Assessment and documented that the whereabouts of the reported children could not be ascertained. The Safety Assessment appropriately reflected the case circumstances.

On 6/24/19, ACS received the results of a search from the NYC Board of Elections, NYC Department of Probation, NYS OCFS Putative Father Registry and Coler-Goldwater Specialty Hospital and Nursing Facility. There were no records found for the reported family from these respective agencies.

On 7/2/19, ACS received the results of the search request from the National Personnel Records Center, Harlem Hospital Center, Air Force Personnel Center, Kings County Hospital, NYS Department of Motor Vehicles, Bureau of Naval Personnel and the Department of Defense. The results from the respective agencies reflected no records were found for the reported household members.

The allegations of DOA/ fatality of the ten-year-old and IG, LBW and PD/AM of the ten and twelve-year-old by the SM were all unsubstantiated. ACS cited the results of their investigation that yielded the reported family was not found.

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved CFRT in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052122 - Deceased Child, Female, 10 Year(s)	052123 - Mother, Female, 64 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
052122 - Deceased Child, Female, 10 Year(s)	052123 - Mother, Female, 64 Year(s)	Inadequate Guardianship	Unsubstantiated
052122 - Deceased Child, Female, 10 Year(s)	052123 - Mother, Female, 64 Year(s)	DOA / Fatality	Unsubstantiated
052122 - Deceased Child, Female, 10 Year(s)	052123 - Mother, Female, 64 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
052125 - Sibling, Female, 12 Year(s)	052123 - Mother, Female, 64 Year(s)	Inadequate Guardianship	Unsubstantiated
052125 - Sibling, Female, 12 Year(s)	052123 - Mother, Female, 64 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
052125 - Sibling, Female, 12 Year(s)	052123 - Mother, Female, 64 Year(s)	Lacerations / Bruises / Welts	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 completed a diligent search to locate the reported family of this report and found the report to be fictitious.

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? There was no legal activity.

Services Provided to the Family in Response to the Fatality

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

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:
The reported children were found to be non-existent.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The reported parent was found to be non-existent.

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/17/2018	Deceased Child, Female, 12 Years	Mother, Female, 35 Years	Excessive Corporal Punishment	Unsubstantiated	No
	Deceased Child, Female, 12 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 12 Years	Mother, Female, 35 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 35 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 35 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
Since last week, the BM has been whipping the twelve and ten-year-old children on a daily basis as a form of punishment. The BM has whipped each child at least 20 times each since last week. Most recently, on 4/17/18, the BM beat the twelve-year-old with a belt to punish her and she sustained welts on her buttocks as a result. On 4/16/18, the BM beat the ten-year-old with a bullwhip causing her to sustain welts on her back and buttocks.

Report Determination: Unfounded | **Date of Determination:** 05/14/2018

Basis for Determination:
ACS noted that they were not able to locate the family and the report appeared to be a false report.

OCFS Review Results:
The investigation was thorough.

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

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

There is extensive history of SCR reports dating back to 2008 involving this family. The reports had similar allegations for children at the reported case; however, no such children appeared to exist. The numerous reports consisted of different names and dates of birth for the reported family members at the same case address.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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

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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