Child Fatality Report

Report Identification Number: NY-17-008

Prepared by: New York City Regional Office

Issue Date: Jul 25, 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	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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	

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 01/26/2017
Initial Date OCFS Notified: 01/26/2017

Presenting Information

The 1/26/17 report alleged that between the night of 1/25/17 and morning of 1/26/17, the SM beat 4-year-old SC with a broomstick. The SM struck the SC on the forehead, neck, back, chest, buttocks, and abdomen until the SC was unconscious. The SC sustained abrasions and contusions from the hitting during the incident. On 1/26/17, the SC went into cardiac arrest and passed away as a result of the injuries sustained during the beating.

Executive Summary

The 4-year-old male child (SC) died on 1/26/17. As of 7/3/17, NYCRO has not received a copy of the autopsy report.

The allegations of the 1/26/17 report were DOA/Fatality, IG, and L/B/W of the SC by the SM. Documentation did not reflect that the SC's father or the 9-year-old child's father were contacted and interviewed by ACS.

ACS learned that according to LE, on 1/25/17 at about 11:00 AM when the SM woke she found the Parent Substitute (PS), and father of the infant and 1-year-old children, went out of the home and left her alone with the children. The SM said she felt overwhelmed because she had to wake up every four hours to feed the infant and attend to the 1-year-old child. During the afternoon, she was unable to prepare food for the children to eat as the infant and 1-year-old had been crying and they needed her attention. The SM said the SC was hungry so he went into the refrigerator and when he opened the door the eggs fell on the ground. As a result, the SM said she hit him on the arm and pushed him causing the SC to hit the wall very hard. The SM then put the 1-year-old child down and hit the SC.

The SM reportedly became very angry and used what was described as a broomstick to beat the SC all over his body. The SM stopped hitting him with the stick once she realized he was not moving. The SM said the SC was conscious and responsive, but appeared to be in shock. The SM sat the SC in the plastic tube (storage bin) in an upright position and filled it with about 3 to 4 inches of water, and returned to the room where she continued to feed the infant. About 20 minutes later, the PS arrived and she told him to check the SC as the SC was quiet. When the PS saw the SC, the SC was slumped over with his face down in the water. The PS climbed into the plastic storage bin/tub and took the SC out of the tub.

Both the SM and PS put cold water on his feet to see whether he would respond because at this time the SC was non-responsive. The SM said she heard the SC make a humming noise. LE said this was a noise that was generally made right before a person was about to expire and a clear indication that the person was dying. The SM saw foam and water coming from the SC’s nose and mouth, and she slapped his face in an attempt to wake him. The PS administered CPR for about 10 minutes and water and foam came from the nose and mouth. After about 10 minutes, the PS called 911.

On 1/26/17, ACS held a conference and the outcome was to file an Article Ten Abuse petition in Kings County Family Court (KCFC). The PS admitted to daily marijuana use while caring for all the children. ACS filed the Article Ten Abuse petition in KCFC naming the SM and PS as respondents. The judge remanded the surviving children to the care and custody of ACS, and granted permission for the SM and PS to visit the surviving children under the supervision of ACS.

ACS added the allegation of II to the Investigation Conclusion Narrative (ICN), but did not add II to the Allegation Information list. ACS did not address the allegation of L/B/W in the ICN. The 24-Hour safety assessment was not completed in a timely manner as it was not completed until 1/30/17. ACS did not complete the 24-Hour Child

Fatality Summary Report within the required timeframe as the document was completed on 1/30/17.

On 3/27/17, ACS SUB the allegations of DOA/Fatality, IG, and L/B/W by the SM. ACS based the determination on the SM's statement and preliminary findings of the autopsy report. According to the preliminary findings, the ME listed the cause of death as multiple blunt trauma injuries and the manner of death as Homicide. The SM inflicted fatal injuries to the SC's vital organs. These injuries directly contributed to his death. The SM's account to LE that she was overwhelmed with the children, and when the SC asked her for food, and she had been so tired with caring for the other children, she acted out of anger hitting him.

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

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

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

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

Explain:
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 was not completed in a timely manner as it was not completed until 1/30/17.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a performance improvement 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/Supervisor Review
Summary:	ACS supervisor approved the determination although ACS added the allegation of II to the Investigation Conclusion Narrative (ICN), but did not add to the 1/26/17 report the allegation of II. ACS did not address the allegation of L/B/W in the ICN.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
Action:	ACS must submit a performance improvement 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:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24 Hour Child fatality Summary Report was not completed timely as it was not completed until 1/30/17.
Legal Reference:	CPS Program Manual, VIII, B.1, page 2
Action:	ACS must submit a performance improvement 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:	Contact/Information From Reporting/Collateral Source
Summary:	Documentation did not reflect that the pediatrician was contacted and interviewed to ascertain whether the children had been seen with marks or bruises.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a performance improvement 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: 01/26/2017 **Time of Death:** 02:35 AM

Date of fatal incident, if different than date of death: 01/25/2017
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes

Time of Call: 08:57 PM
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: SC dropped food on the floor.

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Mother -	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Other Adult - Parent Substitute (father of the 1-year-old and 1-month-old children)	No Role	Male	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Month(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Sibling	No Role	Male	9 Year(s)

LDSS Response

On 1/26/17, the PS said he did not know anything about old bruises on the SC. The PS said on 1/25/17, at around 8:00 PM, he came home and the SM told him to call 911. He asked the SM what was wrong with the SC and the SM said he was not breathing. The SM told him the SC was in the bathroom tub. The PS went to the bathroom and saw him lying in the tub. The PS said the SM stated the SC was not breathing so she put him in the tub and turned on the water to revive him. He said there were some towels around the SC and he was lying on his side. He checked the SC and found he was not breathing and then he called 911 for assistance. When he was on the phone with 911, he performed CPR, but the SC remained unresponsive. EMS arrived and transported the SC to the hospital. The PS said he did not observe any abuse of the SC. The PS admitted to daily use of marijuana. He said he left the SM and children in the home to go to the store. According to ACS, the SM was not interested in being interviewed.

On 1/26/17, ACS filed an Article Ten Abuse petition naming the SM and PS as respondents. The KCFC remanded the three surviving children to the Commissioner of ACS. A full stay away order of protection (OOP) was issued against the respondents except for supervised visitation at the agency. The KCFC ordered the infant and 1-year-old child be

restrictively remanded to the paternal great aunt (PGA). The KCFC issued a limited OOP against the MGF. The documentation reflected the 9-year-old child was released to the care of his MGPs. Documentation reflected that on 1/27/17, ACS visited the home of the PGA to conduct an Emergency Home Study Overview; the home environment seemed safe. On 1/26/17, ACS assessed that the 9-year-old child did not have marks/bruises.

On 1/26/17, the 9-year-old child said the last time he went to the SM's home was on 1/21/17. He stated the SC wet his bed the previous night, and as a result the SC was on punishment. The SC was not permitted to speak to him as the punishment continued throughout the weekend. The 9-year-old child used signs to indicate the SM sometimes used her fist to hit the SC. The 9-year-old child said the home environment was not safe for him as the SM and PS had relocated to reside elsewhere. Later, he said he did not believe the SM meant to kill the SC. He thought the SM killed the SC by accident.

On 1/29/17, ACS staff visited the MGM's home. The 9-year-old child said he was doing well. The MGM said she was with the SC in the hospital the last hour of his life. The MGM said during the hospital visit she observed the bruises, cuts, and scars on his body that were black and blue, and there were old scars. The MGM said the signs were there and she did not see them. When the SM brought the SC to her home he would be wet as he wet the bed often. When she tried to give him a bath, the SM would never permit her to bathe him.

On 2/1/17, ACS held a meeting and addressed the service needs of the children. The 9-year-old child would continue to receive counseling with the Institute of Community Living (ICL). The agreement included stipulation for the caretakers' compliance with the Family Preservation Program (FPP); including home visits, scheduled appointments, and required recommendations; referral of the children and other family members for bereavement counseling; safety homemaking services would be provided at each residence, the infant and 1-year-old child must be provided with weekly contact with the 9-year-old child, and the paternal relatives were advised of the OOP against the PS. The documentation reflected the PS was engaged in a drug treatment program.

The SM was charged with murder in the second degree on 2/27/17. The documentation reflected that the SM was charged with criminal possession of a weapon in the fourth degree, manslaughter in the first degree, and endangering the welfare of a child. The PS was not charged criminally.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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
038483 - Deceased Child, Male, 4 Yrs	038484 - Mother, Female, 26 Year(s)	Lacerations / Bruises / Welts	Substantiated

038483 - Deceased Child, Male, 4 Yrs	038484 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
038483 - Deceased Child, Male, 4 Yrs	038484 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated

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?	☐	☒	☐	☐
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:

The ACS case record did not reflect the SM was interviewed. On 6/21/17, ACS staff sent OCFS a memo indicating the SM was not interested in being interviewed by ACS. LE confiscated the rubber tub and cordoned off the the home as a crime scene.

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:
ACS filed an Article Ten Abuse petition against the parents. ACS was granted a remand of the three surviving children.

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:**
01/26/2017	There was not a fact finding	There was not a disposition
Respondent:	038484 Mother Female 26 Year(s)	
Comments:	On 1/26/17, ACS filed an Article Ten Abuse Petition in the KCFC on behalf of the three surviving children naming the SM and PS as respondents. The KCFC granted the remand of the children to the Commissioner of ACS.	

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
02/27/2017	mother	Unknown	NA
Comments:	The SM was charged with murder in the second degree on 2/27/17. The documentation reflected that the SM was charged with criminal possession of a weapon in the fourth degree, manslaughter in the first degree, and endangering the welfare of a child.		

Have any Orders of Protection been issued? Yes	
From: 04/20/2017	**To:** 07/17/2017
Explain: According to ACS, an order of protection was issued against the MGPs. The order of protection was effective from 4/14/17 through 7/17/17. The MGPs beat the SM as a child and teen. The limited order of protection was against the SM for the same timeframe.	
From: 01/26/2017	**To:** Unknown
Explain: The documentation reflected that an Article Ten petition was filed naming the SM and PS as the respondents. The judge issued a full stay away order of protection against the respondents except for supervised visitation at the agency was issued.	

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Family Preservation Program (FPP)

Additional information, if necessary:
The documentation reflected that FPP was provided and safety homemaking was explored. The MGP's were required to participate in DV counseling and screening as well as parenting for children that experienced trauma. The PS attended a drug treatment program. ACS ordered cribs for the two younger surviving children.

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 infant and 1-year-old child were referred for early intervention screening. These two children have kinship foster care placement with their PGA. The 9-year-old child was released to the care of the MGP's.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM was arrested. The PGA and MGP's were referred to the Family Preservation Program.

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? 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)
01/26/2017	Deceased Child, Male, 4 Years	Other Adult - Parent Substitute, Male, 26 Years	Lack of Supervision	Indicated	Yes
	Deceased Child, Male, 4	Mother, Female, 26 Years	Inadequate Guardianship	Indicated	

	Years				
	Deceased Child, Male, 4 Years	Mother, Female, 26 Years	Lacerations / Bruises / Welts	Indicated	
	Deceased Child, Male, 4 Years	Other Adult - Parent Substitute, Male, 26 Years	Parents Drug / Alcohol Misuse	Indicated	
	Deceased Child, Male, 4 Years	Mother, Female, 26 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 4 Years	Other Adult - Parent Substitute, Male, 26 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 4 Years	Other Adult - Parent Substitute, Male, 26 Years	Lacerations / Bruises / Welts	Indicated	

Report Summary:
The 1/26/17 report alleged that on 1/25/17, the SM reported she left the SC bathing in the tub while she went to breast feed the infant. The SM left the PS to supervise the SC while he was in the tub. She returned 20 minutes later to find the PS gone, and the SC underwater in the tub with only a slight pulse. The SC had fresh bruises on his face and neck. He was also fully dressed in a sweatshirt and sweatpants which made the story of the bath highly suspicious. The SC was found in a storage bin or cooler which was being used as a makeshift tub. The SM was arrested and the SC location was unknown. The SC was taken by EMS to the hospital. His condition was unknown.

Determination: Indicated | **Date of Determination:** 03/27/2017

Basis for Determination:
ACS substantiated the allegations on the basis of the SM's and PS's statement and testimony. The PS failure to take a more active role in the care of his children meant he failed to safeguard them. His actions and behavior created a dangerous environment for the children and by his acts of omission he allowed the SM to care for the 3 children on her own. The PS indicated he was not home as he left to smoke marijuana for the day leaving the SM in the home to care for the 3 children on her own. There was no indication the PS caused the bruising the SC sustained, but there was evidence he knew the ways the SM disciplined the children and saw bruising to the SC's body prior to this incident.

OCFS Review Results:
ACS completed three safety assessments on 1/30/17, 2/6/17, and 3/25/17. ACS went to the Brooklyn Child Advocacy Center (CAC) and interviewed LE official who said he received a call from the hospital indicating the SC was likely to die, came into the hospital in cardiac arrest, seemed brain dead, and not breathing on his own. The SC had old and new bruises on the body. LE said the SC was hungry so he went into the refrigerator and when he opened the door the eggs fell on the ground. The SM hit the SC on the arm and pushed him causing him to hit the wall very hard. She then put the 1-year-old half sibling down and continued to hit the SC.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:

The Seven Day safety assessment of the 1/26/17 report was not completed timely as it was not completed until 2/6/17.

Legal Reference:

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

Action:

ACS must submit a performance improvement 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)
01/25/2017	Deceased Child, Male, 4 Years	Mother, Female, 26 Years	Inadequate Guardianship	Indicated	Yes
	Deceased Child, Male, 4 Years	Mother, Female, 26 Years	Lacerations / Bruises / Welts	Indicated	
	Deceased Child, Male, 4 Years	Mother, Female, 26 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 4 Years	Other Adult - Parent Substitute-, Male, 26 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 4 Years	Other Adult - Parent Substitute-, Male, 26 Years	Lacerations / Bruises / Welts	Indicated	
	Deceased Child, Male, 4 Years	Other Adult - Parent Substitute-, Male, 26 Years	Lack of Supervision	Indicated	
	Deceased Child, Male, 4 Years	Other Adult - Parent Substitute-, Male, 26 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:

The 1/25/17 report alleged that on 1/25/17 prior to 8:15 PM, the SM left the SC unsupervised for an unknown amount of time in a bathtub with standing water in it. The SM then had the PS go in and check the SC. The SC was found face down and not breathing at the time, and went into cardiac arrest as a result. It was unknown if the PS was aware that the child was left unsupervised. It was unknown if the SM had a history of this behavior. The SC had several bruises on his arms, legs, and forehead that the SM claimed were from attempting to resuscitate the SC. The explanation of the injury did not correspond with the sustained injury.

Determination: Indicated | **Date of Determination:** 03/27/2017

Basis for Determination:

ACS based the determination on the SM's and PS statement and testimony. The SM had informed LE that she was overwhelmed with the children and when the SC asked her for food, and she had been so tired with caring for the other children; she became angry and hit the SC. A medical professional indicated the SC had bruising to his forehead, left temple, neck, abrasions on his right abdomen, multiple abrasions on his trunk, upper back, buttocks, right arm and multiple large bruising on his left arm; his whole left arm was bruised. The PS failure to take a more active role in the care of his children, and by his acts of omission he allowed the SM to inflict injuries to the SC.

OCFS Review Results:
ACS completed safety assessments on 1/30/17 and 3/25/17. LE said the SM stated she gave the SC a bath and left the SC unattended in a tub of water for about 20 minutes to feed the infant. The SM asked the PS to check the SC, and the PS found him face down in the water. They performed CPR. LE said the SM reported the SC was breathing when they pulled him out of the tub. The Dr. at the hospital said the SC was not breathing on his own. The SC was found to have abrasions on his forehead, neck, buttocks, back of his legs, and right lower abdomen. SM said the SC may have sustained the abrasions while she attempted to resuscitate him. Dr. said the SM's explanation was not consistent.

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

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
The documentation did not reflect that the PS who was a subject of the report was interviewed by ACS regarding the allegations. Although documentation did reflect that numerous attempts to contact the PS were made; the Investigation Progress Note did not specify the number of attempts and it was unclear whether ACS made diligent efforts to interview the PS.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
ACS must submit a performance improvement 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)
01/28/2015	Sibling, Male, 7 Years	Grandparent, Female, 52 Years	Excessive Corporal Punishment	Unfounded	Yes

Report Summary:
The 1/28/15 report alleged that on a weekly basis as a form of punishment, the grandfather used shoes to spank/hit the half sibling who lived in the grandfather's home. On one occasion, the grandfather hit the child so hard in the knee, it hurt for the child to walk.

Determination: Unfounded **Date of Determination:** 03/05/2015

Basis for Determination:
ACS unsubstantiated the allegation of the 1/28/15 report on the basis of lack of credible evidence to support the allegation. ACS noted the MGM said the spanking of the half sibling occurred several months prior to 1/28/15. It was noted that the MGM did not normally hit the half sibling as a means of punishment. The MGF, MGM and half sibling reported that the spanking was the result of the breaking of the MGM's sink after finding out his mother was not coming to get him for the weekend and throwing a chair at a classmate after the mother did not attend his school assembly. All family members reported that the half sibling was not disciplined in the manner reported.

OCFS Review Results:
ACS completed safety assessments on 2/4/15, 3/4/15 (two), and 3/5/15. One of the assessments on 3/4/15 was a safety

modification.

The SM brought the half-sibling for counseling services with a service provider. The service provider said the half-sibling disclosed he was hit by the MGM with a shoe. The MGF said the MGM hit the half sibling with a flimsy and spongy slipper after the half sibling broke their porcelain sink. The half sibling said the MGM hit him for breaking her new sink and throwing a chair at a child in school. The MGM owned her own daycare. The MGM signed an agreement to receive counseling services for the half sibling with PPRS.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
ACS did not make follow-up casework contact with the service provider agency to ascertain whether the half sibling attended treatment/counseling, and the outcome of the service plan implementation.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
ACS must submit a performance improvement 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)
12/11/2014	Sibling, Male, 7 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 7 Years	Mother, Female, 24 Years	Lack of Medical Care	Unfounded	

Report Summary:
The 12/11/14 report alleged that the half sibling had ongoing clinical health issues and on multiple occasions had expressed wanting to hurt and kill himself. On 12/10/14, he attempted to cut himself with scissors. The SM was aware and the child had been referred for counseling multiple times, yet the SM had failed to seek any medical treatment for the child.

Determination: Unfounded | **Date of Determination:** 02/09/2015

Basis for Determination:
ACS based the determination on lack of credible evidence to substantiate the allegations. The school staff stated the SM was referred for services but was unable to provide the information regarding the name of the providers and the date of referrals. Prior to ACS involvement, the half sibling was sent to Brookdale Hospital ER to address his attempts to harm himself. The MGF and SM were in the ER at the time the half sibling was assessed and evaluated. The evaluation reflected that the half sibling was not a danger to himself and others. The MGF took the half sibling to his follow-up clinical health appointment.

OCFS Review Results:
ACS completed three safety assessments dated 12/18/14 and 2/6/15 (two). The documentation reflected that the half sibling displayed difficult behavior in school. The half sibling had been seeking attention from SM. The SM approved recommendation for the half sibling to receive individual and group counseling in school. The SM applied and signed an agreement for counseling services for the half-sibling with Jewish Board and Family Services. PPRS was initiated and assigned to Catholic Charities. ACS opened a Family Service Stage on 1/8/15. The FSS was closed on 4/30/15.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
During the investigation, the SM said she was planning her wedding; however, ACS did not interview the mother about her plans for changes in the household composition.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
ACS must submit a performance improvement 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)
05/30/2014	Sibling, Male, 6 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	Yes
	Sibling, Male, 6 Years	Mother, Female, 24 Years	Lack of Supervision	Unfounded	

Report Summary:
The 5/30/14 report alleged that the SM allowed the half sibling, who was then 6 years old, to walk to school by himself every morning. The child was very impulsive and he crossed busy intersections where he could be hit by a vehicle due to his immaturity. The child waited to be picked up from school sometimes for over an hour. The SM allowed strangers to pick him up from school to the point where on 5/30/14, the SM did not know the person that picked up the child from school and thought the child was kidnapped.

Determination: Unfounded | **Date of Determination:** 07/25/2014

Basis for Determination:
ACS unsubstantiated the allegations on basis that the SM met the half sibling's basic needs for food, clothing, medical care, and academics. The half sibling was observably clean, neat, and without injury. ACS noted the SM was running late to pick up the half sibling from school. The school permitted someone else to pick up the half sibling, and he left school. The school had no idea who he was with, and was not aware that the SM was not the person who picked up the half sibling. The SM found the half sibling at the home of a neighbor and family friend after knocking on doors in the neighborhood. The SM did not permit the half sibling to walk to and from school alone in the morning.

OCFS Review Results:
ACS completed two safety assessments on 6/6/14 and 7/24/14. Both safety assessments reflected safety factors existed but did not rise to the level of immediate or impending danger of serious harm.

The SM declined PPRS but agreed to obtain services through a Community Based Organization (CBO). ACS provided the SM with a CBO referral as the family had unstable housing condition. The SM informed ACS that she was discharged from the shelter in Queens due to not returning to sign in everyday as she was at the MGM's home. During the investigation, the SM resided MGM's home.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:

The documentation did not reflect that ACS attempted to obtain pertinent information from relevant collateral contacts to verify whether the SM allowed the half sibling to walk to school with adult supervision. ACS did not interview the family friend who had information about the SM supervision of the half sibling.

Legal Reference:

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

Action:

ACS must submit a performance improvement 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 PS was not known to the SCR or ACS. The SM was not known to the SCR or ACS as subject more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☒Yes ☐No

Issue:	Adequacy of case planning
Summary:	The Catholic Charities agency documentation did not reflect that the agency interviewed the service provider agency JCCA to obtain a progress and attendance report regarding the half sibling.
Legal Reference:	18 NYCRR 432.2 (b)(2)
Action:	ACS must submit a performance improvement 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 12/11/14 investigation, ACS opened a Family Service Stage (FSS) on 1/8/15 for PPRS. The Catholic Charities agency had case management responsibility. The 2/7/15 FASP reflected the half sibling had expressed he wanted to hurt and kill himself. The half-sibling attempted to cut himself with scissors. The SM was aware of the half sibling's condition and the half sibling was referred for counseling multiple times, yet the SM had failed to seek the prescribed medical treatment. The Family Service Progress Notes (FSPN) of 2/24/15 reflected that the SM lived with the SC. The then 7-year-old half sibling resided with the MGP's. The PPRS agency inquired of the SM regarding the status of the half sibling's counseling with Jewish Child Care Association (JCCA). The SM reported it was difficult for her to bring him to counseling, but the MGF had been accompanying the half sibling to the appointments. ACS was asked whether there was preference with the agency of JCCA or Catholic Charities. ACS was focused on getting the family in-house casework

counseling. The half sibling was engaged in services at JCCA. A service termination conference occurred on 3/30/15. A consensus decision was made to close the PPRS case as the MGM did not want to participate in services.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

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

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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