NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-046 **Prepared by: New York City Regional Office**

Issue Date: 12/17/2015

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
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	MN-Medical Neglect	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		

Case Information

Report Type: Child Deceased
Age: 14 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 05/22/2015
Initial Date OCFS Notified: 05/22/2015

Presenting Information

The 5/22/15 SCR Additional Information report stated on 5/22/15 at 8:30 A.M., outside of the child's apartment building, a gang member from an opposing gang shot and killed the fourteen-year-old child, who allegedly was on his way to school. The child was shot in the head and torso. It was unknown whether the other family members were inside their apartment at the time of the shooting.

Executive Summary

This fourteen-year-old male child died on 5/22/15. The ME listed the cause of death as multiple gunshot wounds of neck and torso with perforations of airway, lungs, liver, kidney, spleen, and blood vessels and the manner of death as homicide.

On 5/22/15, the SCR registered additional information pertaining to this child's death. The SCR noted that the 5/22/15 report would be additional information under the open case number. ACS included the information in the open 5/13/15 investigation for further exploration. ACS completed the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive cases notifying OCFS of the child's death. The information regarding the child's death was submitted under Chapter 485 of the Laws of 2006.

ACS' findings showed on 5/22/15, at about 8:30 AM, the child left the home to travel to school. He was in front of the case address when he was shot and killed. ACS did not establish the official time of death. It was suspected that the shooting was gang related. ACS was unable to confirm whether the child had gang affiliation.

During the 5/22/15 home visit, the staff observed extended family members who had been providing support to the family. The ACS staff discussed the need for safety planning for the surviving siblings. Due to the mother's grief and her observable tiredness, on 5/22/15, the ACS Specialist and investigative consultant were unable to conduct full interviews. On 5/27/15, ACS contacted the father who said he was unavailable for interview until after 5/28/15, following the child's burial service. ACS learned that the father provided the finances for the child's burial.

ACS maintained contact with the family members who continued to express fear of residing in the neighborhood. ACS' staff contacted the District Attorney's office, the crimes victim liaison and housing staff and assisted with housing advocacy. On 6/1/15, ACS staff visited the local precinct and was informed that there was no arrest regarding the death. On 7/14/15, an officer informed ACS that the police could not release information about the open criminal investigation.

ACS experienced delay in obtaining information through the school, medical and police contacts. An Investigation Progress Note dated 6/1/15, showed ACS contacted the twelve-year-old sibling's school to discuss plans for school transfer. However, ACS' case record did not include additional information to determine whether the school transfer occurred. Also, on 6/8/15, ACS staff visited Bronx Lebanon Hospital, requested the medical record for the child and was directed to FDNY to follow up with the request. The case record did not reflect ACS received the medical

records. On 5/27/15, the mother informed ACS that the seventeen-year-old sibling was involved in an incident and LE had intervened. However, ACS' case record did not include official information about the outcome of the incident to determine whether ACS intervention was needed.

On 7/29/15, ACS' staff last observed the twelve-year-old sibling in his home. The staff noted that this sibling did not have marks or bruises. On 8/4/15, ACS' staff accompanied the mother to the New York City Housing Authority (NYCHA) interview. The mother was required to submit additional documents to NYCHA to complete the housing transfer. The ACS case record did not establish whether the family actually relocated. On 8/13/15, the ACS staff last observed the seventeen-year-old sibling in the father's new home. The documentation did not include details about the seventeen-year-old sibling's service needs. During the visit, the father was not in the home and he did not make himself available for The ACS case record showed the step-mother and half sibling were in the home. However, the case documentation did not demonstrate whether the half sibling was closely observed or engaged.

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?** N/A
  - **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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
N/A

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Required data and official documents
Summary:	The ACS case record did not indicate that the agency obtained updated official records about the seventeen-year-old sibling's involvement with law enforcement, the family's housing transfer and the official time the child was pronounced dead.

Legal Reference:	428.3(b)(2)(i)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The seventeen-year-old sibling relocated to reside with the father. The father did not make himself available for an interview or assessment. However, the 6/29/15 RAP did not reflect the father's unwillingness to address this sibling's needs.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/22/2015 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: BRONX
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? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Travelling to school

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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	No Role	Male	14 Year(s)
Deceased Child's Household	Mother	No Role	Female	39 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)
Other Household 1	Father	No Role	Male	41 Year(s)

LDSS Response

On 5/22/15, the SCR recorded additional information regarding the death of the fourteen-year-old child. The SCR noted that the report would be additional information under an open 5/13/15 case.

On the same day, ACS' staff visited the mother and two surviving siblings in the home. The mother said due to the shooting incident in which the child was killed, she planned to keep the surviving siblings in the home and not send them to school. The staff noted the mother was very emotional and exhausted and ACS' staff informed the mother of plans to follow up with the interview. The siblings informed ACS staff that they did not observe the shooting incident. ACS' staff observed there were several extended family members who supported the mother and children in the home.

During a 5/23/15 home visit, the mother said the child was shot and killed while waiting for a taxi to transport him to school. The ACS staff, mother and seventeen-year-old sibling discussed the possibility of the family relocating to reside in a different neighborhood. This sibling stressed the need for relocation. He said the child was in a gang. He explained that the child quit the gang because he did not like violence. He explained that prior to the time of death, the child expressed fear because some people in the neighborhood wanted the child to be in their gang. The seventeen-year-old sibling showed the Specialist a healed linear 1 ¼ inches mark on the right side of his nose and he said he sustained the wound during an incident in which someone slashed him and ran away. He said his home window was broken several times as a result of people throwing objects at the window. The Specialist observed what appeared to be a gunshot hole in a window near the stairway. The ACS case record showed, during the 5/23/15 home visit, ACS did not provide appropriate language interpretation service to the mother who was a limited English proficiency client.

Regarding information obtained from collateral contacts, the school staff said the younger sibling had behavioral issues for which he continued to receive risk counseling services in school. The ACS 7/8/15 contact with the District Attorney's crimes victim liaison showed the family applied for NYCHA priority housing. Subsequently, the ACS staff accompanied the mother to the NYCHA interview to advocate for relocation. The staff noted that the family was expected to receive trauma based therapy services. The Specialist visited the Bronx Lebanon Hospital and requested medical records for the deceased child. On 7/10/15, ACS staff interviewed the ME who listed the cause of death as multiple gunshot wounds of the neck and torso and the manner as homicide.

The ACS case record did not include official records about a 5/26/15 police incident which allegedly involved the seventeen-year-old sibling. The mother said this sibling relocated to temporarily reside with the maternal uncle out of New York. On 6/7/15, this sibling reportedly returned to New York to follow up with the criminal case and was expected to leave New York on 6/11/15. On 7/13/15, ACS opened the case in the Family Services Stage (FSS) for the purpose of monitoring the family. ACS' staff contacted the Department of Social Services (DSS) in the state in which the older sibling reportedly resided, and requested a courtesy home visit to the MU's home. However, the ACS did not indicate that the courtesy visit had occurred.

On 8/4/15, the Specialist observed the twelve-year-old sibling in the mother's home. This sibling was observably free of

marks/bruises. On 8/13/15, the Specialist observed the older sibling in the father's new apartment. This sibling reported being excited about starting a new education program. ACS' staff did not engage the father, step mother and half sibling. According to ACS' case record, the father did not make himself available for an interview with ACS.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☒	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
According to the case record, on 7/14/15, an assigned police officer informed ACS that no information would be released as there was an active criminal case. This was not in keeping with the previously approved protocols for joint investigations.

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 and 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?				

Explain as necessary:
N/A

Legal Activity Related to the Fatality

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

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 opened the Family Services Stage of the case and the agency monitored the housing, bereavement and educational

needs.

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:
Following the child's death, the ACS staff visited the twelve-year-old child's school and addressed his educational and safety needs. ACS staff conducted follow up casework activities and obtained information which showed that the seventeen-year-old sibling relocated to reside with the father at a new address.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided counseling and support services to address safety, housing and educational concerns. The ACS Specialist accompanied the mother to New York City Housing Authority to assist with housing transfer.

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)
03/04/2014	5722 - Deceased Child, Male, 13 Years	5721 - Mother, Female, 38 Years	Inadequate Guardianship	Indicated	Yes
	5723 - Sibling, Male, 16 Years	5721 - Mother, Female, 38 Years	Lack of Supervision	Indicated	
	5722 - Deceased Child, Male, 13 Years	5721 - Mother, Female, 38 Years	Lack of Supervision	Indicated	
	5723 - Sibling, Male, 16 Years	5721 - Mother, Female, 38 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 3/4/14 SCR report alleged the mother had no control over the child and sibling, who were then thirteen years old and sixteen years old, respectively. The report also alleged the mother allowed her children to roam the streets late at night,

even though she was aware of their behavioral concerns. The children had a history of vandalizing the neighborhood. In 2013, the children damaged a brand new car. Five months prior to 3/4/14, the children damaged a Mercedes. Two weeks previously, the children damaged a window at a beauty salon. The lack of supervision in the home placed the children at risk of harm.

Determination: Indicated	**Date of Determination:** 04/30/2014

Basis for Determination:

ACS substantiated the allegations of IG and LS of the child and sibling who were listed in the 3/4/14 report by the mother on the basis that both children admitted they vandalized other people's property in the neighborhood. The thirteen-year-old child was "monitored by the adjustment department in probation." ACS added that the mother was unable to provide adequate supervision for the children. The mother had history with similar allegations and the children continued to behave in the same manner. ACS noted there was credible evidence to substantiate the allegations.

OCFS Review Results:

ACS' staff observed and engaged the mother and children in the home and ACS borough office. The mother denied the allegations of the report. She admitted that the two older children damaged property and she claimed she addressed these incidents. ACS' staff did not engage or interview the deceased child and older sibling within the required timeframe. ACS' findings showed the deceased child continued to misbehave, law enforcement intervened and a Family Court judge referred him to the adjustment services department of probation. ACS' safety assessments did not include a safety plan and the risk assessment did not reflect the mother's lack of understanding of the case circumstances.

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

Issue:

Adequacy of face-to-face contacts with the child and/or childs parents or guardians

Summary:

The ACS case record did not include information to verify whether the staff engaged and interviewed the older sibling about the allegations of the report.

Legal Reference:

432.1 (o)

Action:

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

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

The Investigation Progress Notes focused on the mother and two of the children's accounts but did not include key information about the father, the community based organization that provided services to the younger sibling and follow up with law enforcement regarding the older sibling.

Legal Reference:

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

Action:

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

Issue:

Predetermination/Assessment of Current Safety and Risk

Summary:
The case record did not include a safety plan for the family. The ACS case record did not include required details to assess safety and risk to include the older sibling. ACS completed a Risk Assessment Profile which did not reflect the mother's lack of understanding of the seriousness of the deceased child's behavior.

Legal Reference:
18 NYCRR 432.1(aa)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/01/2014	5734 - Sibling, Male, 11 Years	5735 - Father, Male, 41 Years	Inadequate Guardianship	Unfounded	Yes

Report Summary:
The 8/1/14 SCR report alleged that about two months prior to 8/1/14, the father hit the stepmother in the presence of the then eleven-year-old sibling for unknown reasons. The report stated that this sibling was not injured. Further details were unknown. The role of the mother and the other two children were unknown.

Determination: Unfounded | **Date of Determination:** 09/03/2014

Basis for Determination:
ACS unsubstantiated the allegation of IG of the eleven-year-old sibling by the father on the basis that this sibling denied that he observed the father hit the stepmother. ACS noted that this sibling said he only observed the father and stepmother engaged in an argument. ACS staff interviewed the father and stepmother and they denied the allegations. The ACS staff was unable to find the domestic violence incident regarding the father and stepmother. ACS did not find credible evidence to substantiate the allegation.

OCFS Review Results:
On 8/5/14, ACS staff observed and interviewed the family members in the ACS borough office. On 8/8/14, ACS' staff made telephone contact with the younger sibling who was in the temporary care of the MGM in a foreign country. ACS adequately addressed the allegations of the report, assessed home conditions and completed the required safety and risk assessments documents. The family continued to receive PPRS.

However, ACS did not assess the safety of the children who resided in the two households within 24 hours of receipt of the 8/1/14 report. Also, the ACS case record did not include follow up information about the Family Court case pertaining to the then sixteen-year-old sibling.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
ACS did not obtain information from pertinent collateral contacts to make an initial assessment of the children's safety within 24 hours of receipt of the 8/1/14 SCR report. Also, the agency did not contact Family Court to follow up with service needs for the older sibling.

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

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/26/2013	5712 - Deceased Child, Male, 12 Years	5711 - Mother, Female, 37 Years	Inadequate Guardianship	Unfounded	No
	5714 - Sibling, Male, 10 Years	5711 - Mother, Female, 37 Years	Lack of Supervision	Unfounded	
	5712 - Deceased Child, Male, 12 Years	5711 - Mother, Female, 37 Years	Lack of Supervision	Unfounded	
	5713 - Sibling, Male, 15 Years	5711 - Mother, Female, 37 Years	Lack of Supervision	Unfounded	
	5714 - Sibling, Male, 10 Years	5711 - Mother, Female, 37 Years	Inadequate Guardianship	Unfounded	
	5713 - Sibling, Male, 15 Years	5711 - Mother, Female, 37 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The 4/26/13 SCR report alleged that the three children were out of control. The report also alleged that these children ran around the neighborhood unsupervised and vandalized the neighbor's property. The children stayed out until midnight on most nights. The mother did not know the children's whereabouts nor did she attempt to locate them. The children played in the middle of streets that had a high traffic volume. This was an ongoing problem.

The 5/21/13 subsequent report included similar allegations to the 4/26/13 report.

Determination: Unfounded | **Date of Determination:** 06/06/2013

Basis for Determination:
ACS consolidated the investigation of the 5/21/13 report into the ongoing 4/26/13 report. ACS unsubstantiated the allegations of IG and LS of the three children by the mother on the basis of lack of credible evidence to substantiate the allegations. In the Investigation Conclusion Narrative, ACS noted that the ACS staff interviewed the children and mother and they denied that the children were left unattended or went out late at nights. ACS added that the staff interviewed collaterals and found no credible evidence to substantiate the allegations.

OCFS Review Results:
On 4/27/13, ACS' staff interviewed the mother and observed the three children in the home. The mother denied the children were left unsupervised late at nights. On 4/27/13, the staff engaged the then ten-year-old sibling but did not engage the SC and older sibling. Between 4/29/13 and 6/4/13, the staff made follow up home visits and interviewed the children who reported they played in front of the home and they were usually at home and asleep by 9:00 PM. The staff observed the children did not have marks or bruises. ACS made adequate collateral contacts. The safety assessment reflected there was no safety factor that placed the children in immediate danger.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/13/2015	5799 - Deceased Child, Male, 14 Years	5798 - Mother, Female, 39 Years	Childs Drug / Alcohol Use	Unfounded	No

5799 - Deceased Child, Male, 14 Years	5798 - Mother, Female, 39 Years	Educational Neglect	Unfounded
5799 - Deceased Child, Male, 14 Years	5798 - Mother, Female, 39 Years	Inadequate Guardianship	Unfounded

Report Summary:
The 5/13/15 SCR report alleged the fourteen-year-old child was not attending school. The report also alleged this child missed excessive amounts of days from school for the school year and as a result he failed his classes. The mother was aware but she made no attempt to address the child's attendance. The child smoked marijuana and sold marijuana. The mother was aware and failed to protect the child. The child was out in the street all the time with a girl during the hours he is supposed to be in school. The situation was ongoing. The roles of the two siblings were unknown.

Determination: Unfounded | **Date of Determination:** 07/10/2015

Basis for Determination:
ACS unsubstantiated all the allegation of the 5/13/15 report on the basis that the child tested negative for all substances and he attended school each day but had problems with lateness. In the Investigation Conclusion Narrative, ACS noted the child was shot and killed on 5/22/15 due to gang related activity. The mother received services with the District Attorney's office crime victims unit. The mother would continue working with the Assistant District Attorney to receive trauma based therapy and new housing. ACS' investigation summary did not include an explanation for the agency's decision to unsubstantiate the allegation of IG of the child by the mother.

OCFS Review Results:
ACS engaged and interviewed all the household members within the required timeframe. The mother and children denied the allegations of the report. ACS found the child had been attending school and there was no evidence that he used drugs. ACS obtained the medical records for the child and older sibling. The medial records showed these children were healthy. On 5/22/15, the investigation was in progress when ACS learned of the child's death.

ACS' 5/29/15 safety assessment did not include the safety factor that actually placed the child in immediate danger. The Risk Assessment Profile did not reflect two of the children were in the temporary care of relatives prior to the report.

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

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

The family was known in a report dated 1/29/12. The allegations were IG and LS of the child (deceased) and two siblings by the mother and parent substitute. The report alleged the children were out of control and they were unsupervised on a regular basis.

On 1/30/12, ACS staff interviewed the mother and three children in the home. ACS addressed the allegations of the report and learned about an incident in which an unrelated adult male assaulted the SC. ACS contacted LE but did not follow up to verify police involvement. ACS' staff observed the three children did not have suspicious marks/bruises. ACS' findings showed beginning November 2011, the two younger children had been receiving counseling services to address behavioral concerns.

According to the ACS case record, in February 2012, the mother tested negative for all substances. The father did not reside in the home but he supported the family. ACS' safety assessment showed there was safety factor that placed the children in immediate danger. In the Risk Assessment Profile, ACS did not include the father. ACS referred the mother for community based services to address previous domestic violence incidents. ACS did not contact the parent substitute who was a subject of the report.

On 3/29/12, ACS unsubstantiated all the allegations of the report. However, in the Investigation Conclusion Summary, ACS did not include an explanation for the parent substitute who was a subject of the report

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

As a result of the investigation of the 3/4/14 report, ACS found that the parents did not adequately supervise the children. The two older children vandalized property, did not always follow rules and they engaged in physical altercations out of the home. The mother and children repeatedly expressed fear of residing in the neighborhood. On 4/30/14, ACS opened the Family Services Stage of the case. The family received case management, monitoring of educational and training needs and therapeutic services. The University Behavioral Association (UBA) agency was assigned case planning responsibility. The UBA staff completed the required quantity of casework contacts to meet the program requirements. On 1/30/15, the UBA staff last observed the mother, child and two siblings in the home. The UBA staff noted these children did not have marks or bruises. On 2/11/15, the UBA agency closed the preventive case after determining that the family no longer needed services.

The Family Services Progress Notes reflected there was a lack of details about the children and their activities. There were several home visits during which at least one child was not in the home or was in the home but did not participate in the therapeutic sessions. The younger sibling visited family relatives abroad and the child and older sibling were sometimes in the care of relatives.

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?
☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** 09/26/2014

Explain:
According to Investigation Progress Note dated 8/14/14, the mother informed ACS of a temporary order of protection (OOP) which the father had filed against the mother. ACS staff noted the OOP was in effect until 9/26/14. On 8/26/14, the ACS staff reviewed the OOP and noted it stated the mother threatened to get a group to beat the father.

During the 8/26/14, face-to face contact, the father informed ACS staff that during telephone conversations, the mother was verbally abusive to him. The father alleged that the mother involved the children in the parents' verbal disputes. The father said he was not interested in receiving services to address the previous domestic violence incidents. An 8/27/14, Investigation Progress Note showed the mother said she planned to attend the September Family Court hearing to dispute the allegations which the father listed in the OOP.

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