

Report Identification Number: NY-17-020

Prepared by: New York City Regional Office

Issue Date: Sep 01, 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 <u>only</u> 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
DrDoctor	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	ACS-Administration for Children's	NYPD-New York City Police
Service	Services	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

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Case Information

Report Type: Child Deceased **Jurisdiction:** Kings **Date of Death:** 11/06/2012

Age: 4 year(s) Gender: Female Initial Date OCFS Notified: 02/26/2017

Presenting Information

The narrative of the report stated in 2008, the BM and the BF engaged in a physical altercation. The BF caused the death of the family's then four-year-old child. The specific details were unknown.

On 2/26/17, the BM gave birth to the newborn SC, and on that same date, the SCR registered a report regarding concerns for the SC's safety. At the time of the SC's birth, the BM's two-year-old son was in kinship foster care with the MGM and she did not plan for the child's return to her care.

Executive Summary

ACS' case records reflected that on 11/6/12, the BM's then four-year-old female child died at the hands of the BM's paramour. The SCR registered a report on the date of the child's death. ACS' Brooklyn Field Office thoroughly investigated the report, and on 1/4/13, substantiated the allegations DOA/FATL, II, IG, L/B/W, and LMC against the BM and her paramour. The BM did not have any surviving children at the time of the SC's death.

On 11/15/12, the paramour was arrested and charged with Murder in the second degree. He was sentenced to a ten-year prison term. On 5/8/13, OCFS' New York City Regional Office issued fatality report number 95-12-083 regarding the child's death.

On 2/26/17, the BM gave birth to the newborn SC, and on the same date the SCR registered a report regarding concerns for the SC's safety. At the time of the SC's birth, the BM's two-year-old son was in kinship foster care with the MGM. The BM had consistently failed to plan for the child's return to her care. In addition, there were clinical health concerns for the BM and her not following through with any type of treatment. Additionally, the BM had a history of criminal activity, and was on probation at the time of the SC's birth.

Due to the BM's failure to fully comply with past court orders and not following through with clinical health treatment, on 2/28/17, ACS added the SC to the existing Article 10 Petition against the BM and requested placement of the SC. Manhattan Family Court granted ACS' request and the SC was placed into kinship foster care with the PGM. On 3/17/17, following the completion of clearances for the BF, the SC was released to the BF with ACS supervision. ACS approved the PGM as a visiting host. The PGM supervised contacts between the BM and the SC and had described the visits as appropriate without any concerns.

On 4/9/17, the SCR registered a subsequent report due to concerns that the BM was alone with the SC while he was admitted to the hospital for medical treatment. The PGM had brought the SC to the hospital on 4/8/17 for treatment, and was with him until she left to attend church on 4/9/17. Prior to leaving, the PGM informed the hospital staff that the BM was not allowed to be left unsupervised with the SC. On 4/14/17, the subsequent report was suspended and closed as a duplicate.

On 5/21/17, ACS substantiated the allegations DOA/FATL and IG against the BM and her paramour. ACS based its decision on the investigation and determination of the 11/6/12 report. Also, ACS substantiated the allegation IG of the BM's two-year-old son and the newborn by the BM.



At the time of writing this report, the BM's two-year-old son remained in kinship foster care with the MGM. The SC was released to the BF; however, he remained in the care of the PGM through a family arrangement. The SC was doing well and no safety concerns had been reported since his birth.

Findings Related to the CPS Investigation of the Fatality

	Incident Information	Activities
Are th	here Required Actions related to the compliance issue(s)? Yes No Fatality-Related Information and Investigative	Activities
	Required Actions Related to the Fatality	
Expla The B	Ain: BM was receiving supervised visits with the child and was engaged in services	. ACS kept the case open for services.
_	there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.
Was c	the decision to close the case appropriate? casework activity commensurate with appropriate and relevant statutory gulatory requirements?	N/A Yes
Expla N/A		
•	Was the determination made by the district to unfound or indicate appropriate?	Yes
•	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.
Deter	mination:	
•	Was the safety decision on the approved Initial Safety Assessment appropriate?	Yes
	 Safety assessment due at the time of determination? 	Yes
	 Approved Initial Safety Assessment? 	Yes
•	y Assessment: Was sufficient information gathered to make the decision recorded on the:	

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lime of fatal incident, if	different than time of death:	06:00 AM
County where fatality in	cident occurred:	Kings
Was 911 or local emerge	ency number called?	Yes
Time of Call:		11:32 AM
Did EMS to respond to t	the scene?	Yes
At time of incident leading	ng to death, had child used alcohol or drugs?	N/A
Child's activity at time o	f incident:	
	☐ Working	Driving / Vehicle occupant
☐ Playing	☐ Eating	Unknown
Other		
Is the caretaker listed in	on at time of incident leading to death? Yes the Household Composition? Yes - Caregiver 2 rvisor was: Not impaired.	
Total number of deaths a	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 on Report	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	28 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)
Other Household 1	Other Child - SC	Alleged Victim	Male	1 Day(s)
Other Household 2	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

On 2/26/17, the Specialist visited the hospital to access the SC and interview the family. The BM repeated the circumstances that led to the death of her then four-year-old daughter. She stated that her two-year-old son was in the kinship care of the MGM. She admitted that she missed a few appointments and visits with the child due to her pregnancy. The BM denied knowledge of the whereabouts of her two-year-old son's BF. She disclosed a past diagnosis of a clinical condition and was taking medication up until her pregnancy. She stated she recently enrolled in a mother/child program but was not prescribed medication.

The Specialist observed the SC being appropriately held by the BM throughout the visit. He did not have any diagnosis or perceived developmental delays. The hospital staff did not report any concerns for the SC. They reported that toxicology tests for the BM were negative.

On 2/27/17, the BM's service provider reported concerns about the BM's failure to comply with prior court orders

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regarding the return of her two-year-old son to her care.

On 2/28/17, ACS held a child safety conference (CSC) with the family. The attendees at the CSC agreed to request a remand for the SC. Consequently, ACS added the SC to the active Article 10 Petition in Manhattan Family Court (MFC) against the BM. Prior to the court proceedings, the BF acknowledged paternity for the SC; however, ACS was unable to assess his ability to care for the SC. ACS requested a temporary release of the SC to the PGM while the BF was cleared. The MFC granted liberal visits between the BM and the SC; supervised by ACS and the PGM.

On 2/28/17, the Specialist assessed the two-year-old child in the MGM's home and did not report any concerns. The child appeared to be doing well.

On 3/1/17, ACS assessed the BF's home and deemed it appropriate for the SC.

On 3/9/17, the PGM reported that the SC was doing well. She reported that the BM visited daily and expressed no concerns about the visitations.

On 3/17/17, the MFC released the SC to the BF's care following the completion of clearances for the BF. The MFC ordered that ACS supervised contacts between the parents and the SC.

On 3/20/17, the BF reported that through an arrangement with the PGM, the SC would remain in the PGM's care.

On 3/30/17, the BF reported that based on his attorney's advice, he was declining services.

On 4/8/17, the SC was admitted to the hospital for a medical treatment, and on 4/9/17, the BM was with the SC in the hospital all day, unsupervised. Consequently, the SCR registered a subsequent report on 4/9/17 due to concerns that the BM was alone with the SC.

Also on 4/9/17, the Specialist visited the hospital to assess the SC. The BM was being supervised by a medical staff at time of the visit. The BM was uncooperative, and refused to be interviewed; however, the Specialist reminded her she was not to be with the SC unsupervised. The Specialist observed the child with no marks or bruises. The medical staff did not report any concerns for the SC. The SC was discharged to the BF on 4/10/17.

On 4/14/17, the 4/9/17 subsequent report was closed as a duplicate. The report was forwarded to the borough office for ongoing assessment.

Between 4/18/17 and 5/4/17, the Specialist made casework contacts with the family. There was no new information regarding the family. The BM's two-year-old son remained in kinship foster care with the MGM. The SC was doing well and no safety concerns had been reported since his birth.

On 5/21/17, ACS substantiated the allegations DOA/FATL and IG against the BM and her paramour. ACS based its decision on the investigation and determination of the 11/6/12 report. Also, ACS substantiated the allegation IG of the BM's two-year-old son and the SC by the BM. As a result of the BM's failure to comply with prior court orders and failure to address the behaviors that posed the two-year-old child at risk; the SC was subsequently neglected.

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

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Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No

Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

Comments: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
040201 - Deceased Child on Report, Female, 4 Year(s)	040204 - Mother's Partner, Male, 28 Year(s)	DOA / Fatality	Substantiated
040201 - Deceased Child on Report, Female, 4 Year(s)	1	Inadequate Guardianship	Substantiated
040201 - Deceased Child on Report, Female, 4 Year(s)	·	Inadequate Guardianship	Substantiated
040201 - Deceased Child on Report, Female, 4 Year(s)	035962 - Mother, Female, 21 Year(s)	DOA / Fatality	Substantiated
040203 - Other Child - SC, Male, 1 Day(s)	·	Inadequate Guardianship	Substantiated
040205 - Sibling, Male, 2 Year(s)	·	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	\boxtimes			
When appropriate, children were interviewed?				
Alleged subject(s) interviewed face-to-face?		\boxtimes		
All 'other persons named' interviewed face-to-face?				
Contact with source?	\boxtimes			
All appropriate Collaterals contacted?		\boxtimes		
First Responders		\boxtimes		
Was a death-scene investigation performed?	\boxtimes			
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?	\boxtimes			
Did the investigation adhere to established protocols for a joint investigation?				

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Was there timely entry of progress notes and other required documentation?	\boxtimes			
Additional information: Both of the siblings named in the report are in kinship foster care and are six-m	onths old	and four-	years-old,	respectively.
Fatality Safety Assessment Activities				
	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	\boxtimes			
Was there an adequate safety assessment of impending or immediate dang in the household named in the report:	ger to sur	viving sib	lings/oth	er children
Within 24 hours?	\boxtimes			
At 7 days?	\boxtimes			
At 30 days?	\boxtimes			
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?	\boxtimes			
Fatality Risk Assessment / Risk Assessment	Dwofila			
Patanty Nisk Assessment / Nisk Assessment	Tome			
	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	\boxtimes			
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?	\boxtimes			
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?	\boxtimes			
Were appropriate/needed services offered in this case				
Placement Activities in Response to the Fatality In	ivesugatio	Ш		
	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving	\boxtimes			

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siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?								
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?								
If Yes, court	ordered?							
On 2/28/17, A The court gra for the BF, th the SC and th	Explain as necessary: On 2/28/17, ACS added the SC to the existing Article 10 Petition against the BM and requested a remand for the SC. The court granted the request and the SC was released to the PGM. On 3/17/17, following the completion of clearances for the BF, the SC was released to the BF with ACS supervision. ACS approved the PGM to monitor the visits between the SC and the BM. The PGM supervised contacts between BM and the SC and had described the visits as appropriate without any concerns.							
		Legal Act	tivity Related	to the Fatalit	y			
`	Was there legal activity as a result of the fatality investigation? ☐ Family Court ☐ Order of Protection							
Criminal Ch	Criminal Charge: Murder Degree: 2							
Date Charges Filed:	Against Whom?	Date of Disposition: Disposition:						
11/15/2015	The Paramour	12	2/31/2012			Gui	lty	
Comments:	On 11/15/12, the paramour v to ten-years imprisonment.					second deg	ree. He w	as sentenced
Have any Or	ders of Protection been issu	ed? No						
	Services P	Provided to	the Family in	Resnonse to	the Fatality	V		
	Services 1	10viaca to	the Lummy in	r response to	the Fatanty			
	Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavalial	N/A	CDR Lead to Referral
Bereavement	t counseling	\boxtimes						
Economic su	pport							
Funeral arra								
Housing assi								
Mental healt	h services							$\perp \perp \perp \perp$
Foster care			$\perp \perp$					$\perp \perp \perp$
Health care								

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NEW YORK and Family Services	Child	Fatalit	y Report	t			
	_		_				
Legal services							
Family planning						\boxtimes	
Homemaking Services						\boxtimes	
Parenting Skills							
Domestic Violence Services							
Early Intervention						\boxtimes	
Alcohol/Substance abuse						\boxtimes	
Child Care						\boxtimes	
Intensive case management						\boxtimes	
Family or others as safety resources						\boxtimes	
Other						\boxtimes	
		•					
	History	Prior to t	he Fatality	y			
Child Information							
•	Oid the child have a history of alleged child abuse/maltreatment? Yes						
=	Vas there an open CPS case with this child at the time of death? Vas the child ever placed outside of the home prior to the death?					No No	
	_			d's death?		No	
	ere there any siblings ever placed outside of the home prior to this child's death? No 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)
03/25/2015	Sibling, Male, 8 Months	Mother, Female, 24 Years	Lack of Medical Care	Indicated	No
	Sibling, Male, 8 Months	Mother, Female, 24 Years	Lack of Supervision	Indicated	

Report Summary:

The BM's then six-month-old medically fragile son required regular and consistent medical follow-ups for the health and safety of the SC. The BM missed specialist appointments for the SC. Hospital staff repeatedly attempted to contact the BM but she failed to respond.

Determination: Indicated **Date of Determination:** 04/22/2015

Basis for Determination:

On 3/21/15, the BM was arrested for shoplifting and had been incarcerated in the State of Georgia. The BM was the sole caretaker for the SC at the time.

OCFS Review Results:

ACS conducted the investigation appropriately.

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)
12/11/2014	Sibling, Male, 4 Months	Mother, Female, 23 Years	Lack of Medical Care	Unfounded	No
	Sibling, Male, 4 Months	Mother, Female, 23 Years	Inadequate Guardianship	Unfounded	
Report Sur	nmary:				
The BM wa	s not giving her then three	e-month-old son his medica	tion on a regular basis for	his medical condi	tion. The SC

Report Summary:

The BM was not giving her then three-month-old son his medication on a regular basis for his medical condition. The SC was at high risk for serious medical crisis. While the PGM was at work, the BM was bringing men into the home and smoking marijuana to impairment in the presence of the SC. The BM would take the SC to parties and leave him with other people to care for him.

Determination: Unfounded

Date of Determination: 02/09/2015

Basis for Determination:

ACS' investigation confirmed that the BM was providing the SC with minimum degree of care and meeting his daily needs food, clothing and shelter. The BM was administering the SC's medication as prescribed. The investigation did not confirm that the BM was abusing any substances at the time.

OCFS Review Results:

ACS conducted the investigation appropriately.

Are there Required Actions related to the compliance issue(s)?

Yes
No

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

Between 1998 and 2008, the BM was known to ACS as a child in eight SCR reports. The allegations of the reports were XCP, L/B/W, IG and LMC. The maternal grandparents and the PGGM were the subjects of the reports. Two of the reports were substantiated against the maternal grandmother (MGM) and the PGGM.

The BM became known to the SCR as a teen parent in a report dated 3/12/09. The report alleged IG and IFCS of her then five-month-old female SC. The BM left the PGGM's home without the means to support the SC. Also, she engaged in criminal activities which jeopardized the SC's safety. On 5/7/09, ACS substantiated the allegations of the report and referred the BM for PPRS.

On 11/6/12, the SCR received three reports regarding the death of the BM's then four-year-old female child. The allegations of the reports were DOA/FATL, IG, II, L/B/W and LMC. The BM and her paramour were the subjects of the reports. ACS' investigation revealed that the paramour repeatedly hit the SC with such force that the SC's intestine ruptured causing internal injuries resulting in her demise. The BM was in the home at the time and did not try to intervene or protect the SC.

On 1/4/13, ACS substantiated the allegations of the reports against the BM and her paramour. The ME reported that the SC died due to of complications of peritonitis due to duodenal perforation, due to blunt trauma of the torso. The paramour was convicted and sentenced to prison for Manslaughter in the death of the SC.

Known CPS History Outside of NYS

The family did not have any 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

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Preventive Services History There is no record of Preventive Services 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 Family Court Petition Type: FCA Article 10 - CPS **Date Filed: Fact Finding Description: Disposition Description:** Article 10 Remand Unknown Adjudicated Neglected **Respondent:** 035962 Mother Female 21 Year(s) **Comments:** Have any Orders of Protection been issued? Yes From: 04/02/2015 To: Unknown **Explain:** On 3/25/15, the BM's then six-month-old medically fragile son required regular and consistent medical follow-ups for the health and safety of the SC. The BM missed specialist appointments for the SC. Hospital staff repeatedly attempted to contact the BM but she failed to respond. The SC remained without the needed medical treatments. On 4/2/15, ACS filed a Neglect Petition at Manhattan Family Court (MFC) against the BM. The MFC granted a remand for the SC and he was placed in the kinship care of his MGM with ACS supervision. New Alternatives for Children was the supervising agency. The court also granted a full-stay away order of protection against the BM.

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	

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