Child Fatality Report

Report Identification Number: NY-16-080

Prepared by: New York City Regional Office

Issue Date: Jul 03, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPR-Cardio-pulmonary Resuscitation		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Others	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 08/02/2016
Initial Date OCFS Notified: 08/03/2016

Presenting Information

On 8/3/16, the SCR registered a report alleging the 3-year-old SC resided with his MGM and her husband, one-and-two-year-old siblings, and the 15-year-old MA. The report noted that on 7/28/16, the SC fell down stairs located at an unspecified location and neither the MGM nor the husband sought medical care for the SC until 7:30 P.M on 7/30/16. The MGM and the husband brought the SC via taxi to the Cohen Children's Hospital. The SC was reportedly unresponsive with no pulse upon arrival to the hospital. The SC was determined to be brain dead and put on a respirator. The SC had subdural hematoma, bleeding at the base of the skull, a herniation and swelling of the brain, bruises to both wrists around the thumb area and bruises on his chest. The report stated the explanation of the SC falling down the stairs was inconsistent with the nature of the injuries. The report further stated the SC was removed from the respirator on 8/2/16 around 11:00AM, at which time he was pronounced dead.

Executive Summary

The SC was three years old when he died on 8/2/16. An autopsy was completed; however, the ME has not issued the report or provided a preliminary cause and manner of death.

The SC's mother was hearing impaired and appeared to have difficulty with securing resources. The parents began residing with the PGPs and other paternal relatives while the mother was pregnant with the SC. The father had no disability; however, all his family members in the household were death mute.

According to the case documentation, the parents ended their relationship at the beginning of 2016 and at that point the mother's housing situation became unstable. The mother could not return to live with the MGM due to their strained relationship.

At the time of the SC's death, there was an active case with the Queens Family Court (QFC) pertaining to a custody petition filed by the MGM on 1/4/16. The mother reported she had no place to live with her children.; therefore, in June 2016, she relinquished custody of her children to the MGM. The MGM was granted temporary custody of the children on 7/5/16 and the next court date was scheduled for 10/6/16. The father had relocated to Herkimer, N.Y.

The family also had an open investigation dated 7/30/16 concerning the events leading to the SC's injuries that lead to his death. This report was indicated on 9/28/16 for allegations of II, LMC, SDS, LBW of the SC and IG of the SC and his sibling by the MGM and her husband.

According to ACS' documentation, on 7/28/16, the SC was left with the MGM's husband while he was installing a safety gate for the stairs leading to the attic. He left the SC unsupervised for about 5 to 10 minutes. The MGM's husband stated he heard a thump and when he returned, he noticed the SC had fallen down the stairs (12 steps). The MGM and her husband stated they checked the SC and he appeared fine. However, following the incident, the SC was lethargic and not eating well.

On 7/29/16, between 11:00 A.M and 11:30 A.M., the MGM placed the SC down for a nap. Sometime between 12:00 P.M and 12:30 P.M., when she returned to check the SC, she had difficulty waking him up. The MGM and her

husband put water on the SC and the SC whined in annoyance. The SC was experiencing difficulty breathing and the MGM and the husband decided to take the SC to the ER. The MGM and the husband noted they attempted CPR, but EMS was not called.

The medical staff who attended to the SC and the ME, found the SC had several visible and internal injuries. The injuries consisted of a subdural hematoma, bleeding at the base of the skull, a herniation and swelling of the brain, bruises to both wrist around. The SC was pronounced dead on 8/2/16 at 11:21 A.M.

On 8/3/16, the SCR registered a report with allegations of DOA, II, LMC, SDS, LBW and IG of the SC by the MGM and her husband.

On 8/3/16, ACS filed an Article 10 Petition on behalf of the SC, his siblings, and the MA. The MGM, her husband and the mother were named as the respondents in the petition. The siblings were released to the PGPs and the MA to her PA. Later in the day, ACS learned of the SC's death.

The QFC also issued full stay-away orders of protection (OOP) against the respondents on behalf of the children and the non-respondent father, on consent, allowing only agency supervised visits for the respondents and unsupervised but scheduled out of the home visits for the father due to a history of arguments with PGF. ACS found 2 domestic incident reports (DIRs) and PGF shared a history of anger issues (not specified). The court ordered ACS supervision of the placement homes.

Despite the SC's injuries, no one was arrested for the death of the child.

On 9/30/16, ACS indicated the report.

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Failure to Provide Notice of Indication
Summary:	The CONNECTIONS event list did not reflect the NOI was issued to the father.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
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; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to provide notice of report
Summary:	The CONNECTIONS event list did not reflect the NOE was issued for the father.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
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; and submit a correction 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: 08/02/2016 **Time of Death:** 11:21 AM

Time of fatal incident, if different than time of death: 11:00 AM

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was: Unknown if they were 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	Aunt/Uncle	No Role	Female	15 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Other Adult	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Other Household 1	Mother	No Role	Female	23 Year(s)
Other Household 2	Father	No Role	Male	25 Year(s)

LDSS Response

ACS conducted the investigations of the 7/30/16 initial report and 8/3/16 fatality reports simultaneously. ACS made collateral contacts with the NYPD, ME, medical staff and family members.

The NYPD detective stated the MGM and her husband took the SC by taxi to Jamaica Hospital on 7/29/16. The SC was unresponsive with multiple injuries when he (SC) arrived at the ER. According to the detective and the medical staff, the MGM's and her husband's explanation for the SC's injuries was not plausible. The SC was placed on a ventilator and then transferred to Cohen's Children's Hospital (CCH) on 7/30/16 for a higher degree of care.

The SC sustained several visible injuries to his body; a subdural hematoma, bleeding at the base of the skull, a herniation and swelling of the brain, bruises to both wrist and his chest. Medical staff found the SC had 36 bruises on his body in different stages of healing. There were no estimated dates to determine when the SC sustained the bruises.

On 7/30/16, ACS' Emergency Children Services (ECS) conducted an emergency removal of the children who resided with the MGM. ECS based their decision on the nature of the SC's injuries as medical staff indicated the MGM's and her husband's explanation was not consistent with the SC's injuries. The SC remained hospitalized and the siblings and MA were placed with relatives.

The surviving children were medically cleared at Queens Hospital and the MA was later interviewed at the Child Advocacy Center (CAC). The progress notes did not reveal the outcome of the visit to the CAC.

On 7/31/16, the medical staff at the CCH indicated the SC's prognosis was poor and there was a high probability the child would die. Medical examination and tests determined the SC was brain dead and he was subsequently removed from the ventilator on 8/2/16.

On 8/2/16, ACS held a Child Safety Conference (CSC) due to the nature of the SC's injuries and the emergency removal of the surviving children and determined court intervention was needed. ACS filed an Article Ten Neglect Petition and family resources were cleared to care for the surviving children.

The MGM and the husband informed ACS the SC was with the MGM's husband at the time of the incident. The MGM's husband reported he was putting a safety gate for the stairs leading to the attic and went to get a measuring tape. He estimated he left the SC unattended for 5 to 10 minutes and he heard a "thump." The MGM's husband said when he returned, he noticed the SC fell down the stairs, but he was not bleeding nor sustained any bruises. The MGM said she was bathing the siblings when the incident occurred, but when she saw the SC he seemed fine. The MA reported she was in her room talking on her cellular phone and did not hear anything.

The MGM and the husband said they continued to monitor the SC who they reported appeared lethargic and was not eating well. However, they did not seek medical attention until they noticed the SC was having difficulty breathing on 7/29/16. The MGM and the husband indicated they administered CPR before taking the SC to the hospital. Their explanation for not calling 911 was they believed EMS would take too long to arrive at the home.

The MGM and her husband filed a 1028 hearing to have the MA returned to their care. The case remained active with the QFC.

On 9/3016, a staff member from the ME contacted ACS to report the autopsy report had not been issued as toxicology results were pending. The case documentation noted it would take approximately one year for the issuance of a report. ACS did not contact the NYPD to ascertain the status of their investigation.

On 9/30/16, ACS substantiated the allegations and indicated the report against the MGM and her husband.

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 investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: The investigation adhered to previously approved protocols for joint investigation.

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
030506 - Deceased Child, Male, 3 Year(s)	034602 - Other Adult - MGM's husband, Male, 39 Year(s)	Internal Injuries	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034601 - Grandparent, Female, 41 Year(s)	Lack of Medical Care	Substantiated
030506 - Deceased Child, Male,	034601 - Grandparent, Female, 41 Year(s)	DOA / Fatality	Substantiated

3 Year(s)			
030506 - Deceased Child, Male, 3 Year(s)	034601 - Grandparent, Female, 41 Year(s)	Swelling / Dislocations / Sprains	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034601 - Grandparent, Female, 41 Year(s)	Inadequate Guardianship	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034602 - Other Adult - MGM's husband, Male, 39 Year(s)	Swelling / Dislocations / Sprains	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034602 - Other Adult - MGM's husband, Male, 39 Year(s)	DOA / Fatality	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034602 - Other Adult - MGM's husband, Male, 39 Year(s)	Lack of Medical Care	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034602 - Other Adult - MGM's husband, Male, 39 Year(s)	Lacerations / Bruises / Welts	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034601 - Grandparent, Female, 41 Year(s)	Lacerations / Bruises / Welts	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034602 - Other Adult - MGM's husband, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
030506 - Deceased Child, Male, 3 Year(s)	034601 - Grandparent, Female, 41 Year(s)	Internal Injuries	Substantiated
030509 - Sibling, Female, 1 Year(s)	034602 - Other Adult - MGM's husband, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
030509 - Sibling, Female, 1 Year(s)	034601 - Grandparent, Female, 41 Year(s)	Inadequate Guardianship	Substantiated
030510 - Sibling, Male, 2 Year(s)	034601 - Grandparent, Female, 41 Year(s)	Inadequate Guardianship	Substantiated
030510 - Sibling, Male, 2 Year(s)	034602 - Other Adult - MGM's husband, Male, 39 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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?	☒	☐	☐	☐

Explain:
A 30 Day safety assessment was not completed.

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: N/A				

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:**
08/03/2016	There was not a fact finding	There was not a disposition
Respondent:	034551 Mother Female 23 Year(s)	
Comments:	On 8/3/16, ACS filed an Article 10 Petition on behalf of the SC, his siblings, and the MA. The MGM, her husband and the mother were named as the respondents in the petition.The siblings were released to the PGPs and the MA to her PA. The QFC also issued full stay-away orders of protection (OOP) against the respondents on behalf of the children and the non-respondent father, on consent, allowing only agency supervised visits for the respondents and unsupervised but scheduled out of the home visits for the father due to a history of arguments with PGF. ACS found 2 domestic incident reports (DIRs) and PGF shared a history of anger issues (not specified). The court ordered ACS supervision of the placement homes.	

Have any Orders of Protection been issued? Yes	
From: 08/03/2016	**To:** Unknown
Explain: On 8/3/16, ACS filed an Article 10 Petition on behalf of the SC, his siblings, and the MA. The MGM, her husband and the mother were named as the respondents in the petition.The siblings were released to the PGPs and the MA to her PA. The QFC also issued full stay-away orders of protection (OOP) against the respondents on behalf of the children and the non-respondent father, on consent, allowing only agency supervised visits for the respondents and unsupervised but scheduled out of the home visits for the father due to a history of arguments with PGF. ACS found 2 domestic incident	

reports (DIRs) and PGF shared a history of anger issues (not specified). The court ordered ACS supervision of the placement homes.

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	☐	☐	☐	☐	☐	☒	☐

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:
ACS conducted an emergency removal. The QFC released the children to relatives

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
N/A

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? Yes

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)
07/30/2016	13887 - Deceased Child, Male, 3 Years	13888 - Grandparent, Female, 41 Years	Internal Injuries	Indicated	Yes
	13887 - Deceased Child, Male, 3 Years	13888 - Grandparent, Female, 41 Years	Swelling / Dislocations / Sprains	Indicated	
	13887 - Deceased Child, Male, 3 Years	13889 - Other Adult - MGM's husband, Male, 39 Years	Internal Injuries	Indicated	
	13887 - Deceased Child, Male, 3 Years	13889 - Other Adult - MGM's husband, Male, 39 Years	Inadequate Guardianship	Indicated	
	13887 - Deceased Child, Male, 3 Years	13888 - Grandparent, Female, 41 Years	Lack of Medical Care	Indicated	
	13887 - Deceased Child, Male, 3 Years	13889 - Other Adult - MGM's husband, Male, 39 Years	Lack of Medical Care	Indicated	
	13894 - Sibling, Male, 1 Years	13889 - Other Adult - MGM's husband, Male, 39 Years	Inadequate Guardianship	Indicated	
	13893 - Sibling, Male, 2 Years	13888 - Grandparent, Female, 41 Years	Inadequate Guardianship	Indicated	
	13894 - Sibling, Male, 1 Years	13888 - Grandparent, Female, 41 Years	Inadequate Guardianship	Indicated	
	13887 - Deceased Child, Male, 3 Years	13888 - Grandparent, Female, 41 Years	Lacerations / Bruises / Welts	Indicated	
	13887 - Deceased Child, Male, 3 Years	13889 - Other Adult - MGM's husband, Male, 39 Years	Lacerations / Bruises / Welts	Indicated	
	13887 - Deceased Child, Male, 3 Years	13889 - Other Adult - MGM's husband, Male, 39 Years	Swelling / Dislocations / Sprains	Indicated	
	13887 - Deceased	13888 - Grandparent, Female,	Inadequate	Indicated	

Child, Male, 3 Years	41 Years	Guardianship	
13893 - Sibling, Male, 2 Years	13889 - Other Adult - MGM's husband, Male, 39 Years	Inadequate Guardianship	Indicated

Report Summary:
The SCR registered 4 reports concerning severe injuries sustained by the SC. At the time of the report, the SC and his siblings were in the temporary custody of the MGM.

According to the MGM and her husband, on 7/28/16, the SC fell down the stairs in the home and became lethargic. On 7/29/16, the MGM and the husband took the SC to the hospital because he had difficulty breathing. Medical staff determined the MGM's and her husband's account were not consistent with the injuries. On 7/30/16, ACS conducted an emergency removal of the MA and the siblings who resided in the MGM's home.

The SC succumbed to his death on 8/2/16.

Determination: Indicated | **Date of Determination:** 09/28/2016

Basis for Determination:
ACS substantiated the allegations of II, IG, L/B/W LMC and SDS of the SC by the MGM and her husband. ACS based their decision on the SC's injuries and the fact that the subjects delayed seeking medical attention.

OCFS Review Results:
NYCRO's review revealed ACS appropriately conducted an emergency removal of the surviving children and proceeded to follow up with filing an Article Ten Neglect Petition. ACS also identified family resources in a timely manner.

In completing the safety assessments, ACS made an appropriate safety decsion. However, the safety factors selected and supporting comments were not consistent with the case circumstances.

ACS indicated the report; however, did not generate the notices of indication from the CONNECTIONS event list.

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

Issue:
Failure to Provide Notice of Indication
Summary:
The CONNECTIONS event list does not reflect the NOIs were issued to the subjects nor the parents.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
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; and submit a correction 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:
ACS made the appropriate decision, but did not select safety factors consistent to the family's circumstances.
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; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The safety assessment was completed timely with an appropriate safety decision. However, the selected safety factors and comments to support these were not consistent with the family circumstances.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(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; and submit a correction 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)
04/10/2016	13821 - Deceased Child, Male, 3 Years	13895 - Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	13821 - Deceased Child, Male, 3 Years	13897 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13899 - Sibling, Male, 2 Years	13897 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13906 - Sibling, Male, 1 Years	13897 - Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13899 - Sibling, Male, 2 Years	13895 - Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13906 - Sibling, Male, 1 Years	13895 - Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	13899 - Sibling, Male, 2 Years	13897 - Father, Male, 25 Years	Lack of Medical Care	Unfounded	
	13821 - Deceased Child, Male, 3 Years	13895 - Mother, Female, 22 Years	Lack of Medical Care	Unfounded	
	13899 - Sibling, Male, 2 Years	13895 - Mother, Female, 22 Years	Lack of Medical Care	Unfounded	
	13906 - Sibling, Male, 1 Years	13895 - Mother, Female, 22 Years	Lack of Medical Care	Unfounded	
	13821 - Deceased Child, Male, 3 Years	13897 - Father, Male, 25 Years	Lack of Medical Care	Unfounded	
	13906 - Sibling, Male, 1 Years	13897 - Father, Male, 25 Years	Lack of Medical Care	Unfounded	

Report Summary:
The report alleged the SC and his siblings were not properly fed or receiving adequate medical care. It was also alleged they were unsafe due to the BM's instability.

The petition filed by the MGM for the custody of the 3 children continued active. The QFC ordered ACS to obtain clinical records for the BM. Documentation did not reflect information concerning the BM's clinical history.

The parents separated on 3/27/2016, however, they denied there was DV in their relationship. The BF secured housing in Herkimer. N.Y., but the mother refused to move upstate. ACS did not contact the county for a home assessment or availability of services for the family.

Determination: Unfounded | **Date of Determination:** 06/09/2016

Basis for Determination:

ACS unsubstantiated the allegations of IF/C/S and LMC of the SC and his sibling by the parents. ACS cited there was no evidence to substantiate the allegations. ACS documented the "family" was residing with the MGF and his wife and the children were always observed to be clean. ACS also noted there was food in the home and the home was always clean.

ACS did not address the allegations separately for the parents as the father resided out of the MGF's home. In addition there were no collateral contact with medical provider, EI or the Lexington School for the Deaf where the SC attended to learn sign language.

OCFS Review Results:

The coordination of providing an interpreter for the family was not adequate, as ACS attempted to use family members who could not adequately interpret.

The MGF's wife had concerns about the BM not being motivated to become independent. The BM felt the MGF and his wife did not want her to stay in the home. ACS advised the BM to remain in the MGF's home to show the QFC she had some "housing stability." ACS did not assess the BF's home.

On 4/22/16, ACS was again ordered to obtain clinical records from the hospital where the BM had received treatment. No information was obtained during this period.

The mother accepted a referral for PPRS.

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There was no relevant contact with services, medical provider, EI or the Lexington School for the Deaf where the SC attended to learn sign language. In addition, the information provided by a family member was not considered to assess safety or risk.

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; and submit a correction 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:

ACS did not properly coordinate the interpreting services which impacted the overall investigation. It appears this matter might have hindered the assessment of the family's needs. There was no relevant contact with services providers, medical provider, EI or the Lexington School for the Deaf where the SC attended to learn sign language.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

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; and submit a correction 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 responses for the questions in the RAP were not fully explored. However, the family circumstances are not consistent with some of the responses.

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; and submit a correction 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)
01/04/2016	14002 - Deceased Child, Male, 3 Years	14005 - Mother, Female, 22 Years	Inadequate Guardianship	Unfounded	Yes
	14004 - Sibling, Female, 5 Months	14005 - Mother, Female, 22 Years	Lack of Medical Care	Unfounded	
	14003 - Sibling, Male, 1 Years	14005 - Mother, Female, 22 Years	Inadequate Guardianship	Unfounded	
	14004 - Sibling, Female, 5 Months	14007 - Grandparent, Female, 41 Years	Lack of Medical Care	Unfounded	
	14004 - Sibling, Female, 5 Months	14005 - Mother, Female, 22 Years	Inadequate Guardianship	Unfounded	
	14002 - Deceased Child, Male, 3 Years	14007 - Grandparent, Female, 41 Years	Inadequate Guardianship	Unfounded	
	14003 - Sibling, Male, 1 Years	14007 - Grandparent, Female, 41 Years	Inadequate Guardianship	Unfounded	
	14004 - Sibling, Female, 5 Months	14007 - Grandparent, Female, 41 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The QFC ordered an investigation of the family as a result of a petition filed by the MGM requesting custody of the children. It was alleged the BM did not take the SC for medical attention as needed and did not fill a prescription for the SC.

The MGM alleged the BM had a history of hurting herself, using marijuana and, alleged the paternal relatives were keeping the SC because he received SSI. The parents denied the allegations; however, the BM admitted she had clinical issues when she was a teenager.

The SC's doctor confirmed the SC received medical attention in November 2015, but was not prescribed medication. The doctor had no concerns about the medical care of the children.

Determination: Unfounded | **Date of Determination:** 02/22/2016

Basis for Determination:
The allegations of LMC and IG was unsubstantiated against the "parents" noting there was no credible evidence to substantiate the allegations. The narrative noted the children were appropriately cared for by the parents. However, the BF was not added as a subject of the report.

ACS unsubstantiated the allegations against the MGM, but did not provide a narrative to support their decision.

OCFS Review Results:
ACS initiated the investigation and assessed the safety of the children in a timely manner.

ACS did not conduct a thorough investigation as interpreting services were not provided as needed for the BM and paternal relatives. In addition, the parents reported the BM had moved to Pennsylvania (PA). It appears the move was made prior to the MGM filing for custody of the children. ACS failed to request a courtesy visit from PA to assess the BM's home.

The QFC ordered ACS obtain clinical records concerning the BM's mental health treatment. The documentation did not reflect ACS obtained the BM's clinical records.

ACS did not issue the NOI to relevant parties.

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

Issue:
Appropriateness of allegation determination
Summary:
ACS unsubstantiated the allegations against the MGM, but did not provide a narrative to support their decision.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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; and submit a correction 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 responses for the questions in the RAP were not fully explored. However, the family circumstances are not consistent with some of the responses.
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; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to Provide Notice of Indication
Summary:
The CONNECTIONS event list does not reflect ACS issued the NOI to all relevant parties.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction 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:
ACS did not conduct a thorough investigation as interpreting services were not provided as needed for the BM and paternal relatives. In addition, the parents reported the BM had moved to Pennsylvania (PA). It appears the move was made prior to the MGM filing for custody of the children. ACS failed to request a courtesy visit from PA to assess the BM's home.

Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)

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

[redacted]

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

From 1996 through 2010 the BM was known as a child in 7 reports, 1 report was indicated 2 were unfounded. The BM was also listed as a child with no role in 4 additional reports. The allegations of the report were: IF/C/S, L/B/W, LS and XCP and IG.

The MGPs were listed as the subject in an indicated report dated 2/9/96. The BM and the MA were listed as the maltreated children. The allegations were L/B/W of the BM by the MGM and IG of the BM and the MA by the MGPs. It was alleged the MGM was "out of control" forcefully hitting the BM and requested the BM and MA be removed. It was also noted there was DV in the home. The report indicates that the PGGM (SC's) obtained custody of the BM and the MA. On 1/19/16 the indication against the MGM was overturned.

The MGM's husband was listed in an unfounded report dated 2/15/08 for allegations of XCP and L.B/ W of the mother.

Known CPS History Outside of NYS

The family has no known CPS history outside NYS.

Required Action(s)

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

Preventive Services History

During the 4/16/16 investigation the mother had accepted PPRS services; however, she was not linked to any agency.

According to the FSS, ACS had contact with the mother who appeared to be overwhelmed about not having stable housing and she had asked the MGM to help her care for the children. In July, the mother reported that she went to the QFC and relinquished custody of the children to the MGM. Prior to the MGM getting the custody of the children, she was making it difficult for the father to see the children. It appeared the mother wanted to keep her children, but had no concrete resources to help her with caring for them.

The communication with the mother was limited and did not appear to meet her concerns. The interpretation services were not adequately coordinated. There was no offer to refer the children to daycare services while the mother resided with the MGF and his wife. The mother spent most of the day with the MGF's wife who was not trained in ASL.

Prior to the FSS, the father began to plan to take the family to an apartment he had obtained in upstate NY. The father had contacted the DSS and invited ACS to assess the home and to contact DSS. The father provided a name and telephone number for the DSS, but ACS did not assist the father with his request.

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: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
01/04/2016	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	On 8/3/16, ACS filed an Article 10 Petition on behalf of the SC, his siblings, and the MA. The MGM, her husband and the mother were named as the respondents in the petition. The siblings were released to the PGPs and the MA to her PA. The QFC also issued full stay-away orders of protection (OOP) against the respondents on behalf of the children and the non-respondent father, on consent, allowing only agency supervised visits for the respondents and unsupervised but scheduled out of the home visits for the father due to a history of arguments with PGF. ACS found 2 domestic incident reports (DIRs) and PGF shared a history of anger issues (not specified). The court ordered ACS supervision of the placement homes.	

Additional Local District Comments

N/A

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