Child Fatality Report

Report Identification Number: NY-17-055

Prepared by: New York City Regional Office

Issue Date: Nov 20, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 05/21/2017
Initial Date OCFS Notified: 05/23/2017

Presenting Information

OCFS Form-7065 dated 5/26/17 stated that the 16-year-old male CH's body was found in Alley Pond Park with multiple stab wounds on 5/21/17. The report also stated that the PPRS agency was made aware of the CH's death on 5/25/17. As per BM, the CH had been missing since 5/16/17. On 5/19/17, BM reported to the case planner that the CH might have been kidnapped by the MS13 gang because he did not commit a murder he was ordered to do.

Executive Summary

This 16-year-old male CH died on 5/21/17. The CH's body was found in Alley Pond Park. The CH had reportedly sustained multiple stab wounds. On 10/25/17, ACS informed NYCRO that the case was classified a homicide and the District Attorney's office did not allow other details to be released to the public, including ACS. As of 11/17/17, NYCRO had not yet received the ME's report.

The family had an open preventive services case effective 8/1/16. The case was opened after ACS found the BM was unable to manage the 16-year-old and 14-year-old CHN's behavior, and the family had unstable housing conditions and limited resources. ACS assigned case planning responsibility to the Family Support Services, Child Center of New York (CCNY) agency. CCNY learned that the family was evicted from the home on 5/5/17 and the BM had not seen the 16-year-old CH since 5/16/17. CCNY staff visited the BM and five surviving CHN at a public location on 5/22/17. During the visit, the BM said she did want to enter the housing system at the Prevention Assistance Temporary Housing program.

The documentation reflected that on 5/19/17, the BM indicated the 16-year-old CH was probably kidnapped by MS13 gang members for not following through with murder. On 5/22/17, LE informed ACS that police believed they found the body of the 16-year-old CH. After the BM positively identified the body, on 5/23/17, LE advised ACS to refrain from frightening the BM to allow LE to continue to solve the homicide case.

ACS submitted to NYCRO 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. ACS submitted the OCFS Form-7065 within the required timeframe. The information regarding the CH's death was reported to OCFS under Chapter 485 of the Laws of 2006. ACS included the information in the open 5/19/17 investigation.

The Investigation Progress Notes did not indicate ACS observed the BM and surviving CHN within 24 hours of notification of the CH's death. Regarding the delay in safety assessment, a 6/6/17 Investigation Progress Note stated that ACS had allowed the BM some time to organize her situation and allow LE to conduct the police investigation. The case record reflected ACS management staff instructed CCNY staff to focus on providing services to the family and refrain from interfering with LE investigation.

ACS staff interviewed and engaged the BM and CHN at the LDSS office on 6/8/17. ACS assessed that the CHN had no immediate needs. ACS did not visit the family's home until 6/22/17. During the visit, the staff found the CHN seemed healthy and there was no immediate danger of harm. ACS followed up with LE and learned that the BM had cooperated with police investigation and there were no recent changes. After the 6/22/17 home visit, ACS ended casework contact with the family. ACS did not make appropriate assessment of family service needs the documentation did not include details about the role and responsibility of the PS, and the BM's ability to supervise the other 9-year-old male child who was listed in the FASP.

Between July and October 2017, CCNY maintained contact with the family and engaged the BM and CHN through telephone communication and face-to-face visits, and followed up with health, education, financial resources and housing needs. The BM discussed her pregnancy and prenatal care. She said the PS was the father of her unborn child. CCNY found the home was clean and there were no safety concerns. The BM said the PS assisted with supervision of the CHN. CCNY did not obtain additional details about the PS and his 9-year-old son.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
ACS did not obtain pertinent details about the BM's relationship with the PS and his 9-year-old son.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
ACS did not make adequate casework contact to engage all household members.

Required Actions Related to the Fatality

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

Issue:	Adequacy of services following the fatality
Summary:	ACS did not provide services to address the BM's inability to manage the 14-year-old CH's behavior, the caretaking responsibilities of the PS, and supervision of his 9-year-old CH. The BM said the PS was the father of her unborn CH.
Legal Reference:	18 NYCRR 432.2(b)(4);428.6
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/21/2017 **Time of Death:** Unknown

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

County where fatality incident occurred: Queens
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? Unknown
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: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	16 Year(s)
Deceased Child's Household	Mother	No Role	Female	38 Year(s)
Deceased Child's Household	Other Adult - BM's paramour	No Role	Male	34 Year(s)
Deceased Child's Household	Other Child - Paramour's son	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	14 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)

LDSS Response

ACS learned that on 5/5/17 the family had become homeless due to eviction. During a telephone interview with the BM, she agreed to participate in a Child Safety Conference (CSC) scheduled to take palace at an ACS office on 5/23/17. On 5/23/17, ACS received information from LE who said the family was picked up from a public location and transported to a hotel for temporary housing. ACS attempted to obtain additional information from LE; however, the attempts were unsuccessful as LE did not respond. The documentation did not reflect ACS convened the CSC as scheduled.

ACS held a telephone interview with the BM on 5/26/17. ACS utilized language interpretation services and offered "condolence," discussed circumstances of the CH's death, bereavement and burial arrangements, and cooperation with LE investigation. ACS noted that the CH's body had not yet been released for burial. The BM disclosed her fear of MS 13 gang, pregnancy with her 7th child and plans for prenatal services, and housing needs.

ACS monitored the CHN's educational and developmental needs. The ACS Specialist held a clinical consultation for the family on 6/6/17. The recommendations included: possible intensive PPRS to address BM's parenting skills, child safety and role of fathers, DV assessment, home condition, bereavement therapy, mental health evaluation for BM, gang diversion for 14-year-old child, and increased peer socialization and enrichment for all CHN.

During the 6/8/17 face-face contact with ACS, the BM disclosed that on 6/9/17 she planned to send the CH's body to her native country for burial. The BM denied she had a history of DV. She said the BF of the 16-year-old CH was not involved with the family, the father of the 14-year-old and 12-year-old CHN provided some support but could not engage the CHN due to prior sex abuse concerns, and the father of the three younger CHN was involved with the family. ACS discussed the benefits of bereavement counseling. The BM requested counseling through telephone service as she did not want the CHN to be exposed to outside violence. The 14-year-old CH denied he had gang involvement and he said he did not have knowledge of who killed the 16-year-old CH. He admitted he used marijuana he had received from friends at school.

ACS reviewed the surviving CHN's medical records and found the five CHN had well-care examinations between 6/7/17 and 6/15/17. The records reflected the Dr. had no concerns regarding the CHN. ACS did not determine the degree of the 14-year-old CH's marijuana use and possible need for intervention.

The FSPN reflected that on 6/15/17, BM found permanent housing. CCNY staff visited the new home on 6/22/17, observed the five CHN and noted that they did not have marks/bruises. The BM said she had part-time employment and the PS assisted with supervision of the CHN. The BM said she continued to receive pre-natal care at a hospital and was expected to deliver her 7th CH in November 2017. She was reluctant to engage in PPRS activities due to her pregnancy. CCNY discussed obtaining a crib and supplies for the family, monitoring of the family's progress and referring the CHN for therapeutic services after the BM delivers the CH. The BM disclosed to CCNY that the landlord asked the family to relocate due to overcrowding.

In October 2017, the BM informed CCNY that she secured a new apartment that was under repairs. Regarding the 14-year-old CH, CCNY noted the there was an open legal case and referral of the 14-year-old CH to the Youth Court, diversion program, to address this CH's behavior problems. CCNY did not provide additional information about the 14-year-old CH, and the PS and his 9-year-old male CH although the agency noted there were plans to schedule an Elevated Risk Conference for the family.

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?	☒	☐	☐	☐
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:
ACS did not make observe and engage the PS and his 9-year-old male CH although they were listed in the FASP.

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: ACS received notification of the fatality on 5/23/17; however, the agency conducted the initial safety assessment on 6/22/17.				

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	☒	☐	☐	☐
Explain: CCNY conducted risk assessment that did not include assessment of the PS and his 9-year-old male child.				

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: There was no removal regarding the surviving CHN.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☒	☐	☐	☐	☐	☐	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☒	☐	☐	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐

Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☒	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☒	☐	☐	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The BM said she made burial arrangements in a foreign country. The BM received prenatal care and the family received PPRS.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no immediate needs in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There was no immediate need related to the fatality.

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)
05/19/2017	Sibling, Male, 14 Years	Mother, Female, 38 Years	Inadequate Guardianship	Indicated	Yes

Sibling, Male, 12 Years	Mother, Female, 38 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 16 Years	Mother, Female, 38 Years	Inadequate Guardianship	Indicated

Report Summary:
The 5/19/17 SCR report alleged the 16-year-old CH was a gang member. The report stated the CH had been missing since 5/16/17. The BM had not contacted LE or filed a missing person report to help ensure the safety of the CH. The BM had been evicted from the home. The BM did not make adequate plans for the CHN ages 14 and 12 years, and these CHN did not have a place to go throughout the day, placing them at risk of harm. The CHN did not have a place to sleep. As a result, the CHN were in need of protection. The CHN ages 10, 9, and 7 years had unknown roles.

Determination: Indicated **Date of Determination:** 07/12/2017

Basis for Determination:
ACS substantiated the allegation of IG of the subject CHN by the BM on the basis that the BM made inappropriate living arrangements for these CHN. ACS explained that there appeared to be a pattern with the family as the CHN had roamed the streets until the family resource returned from work. There had been concerns regarding the 16-year-old and 14-year-old CHN being gang affiliated. The BM was aware the CHN were part of the MS 13 gang. ACS added that the 16-year-old CH was murdered.

OCFS Review Results:
ACS initiated the investigation within 24 hours of receipt of the 5/19/17 report but did not observe the surviving CHN until 5/22/17. ACS found the family was evicted from their home and had relocated to reside with family relatives. The BM said she had not seen the 16-year-old child since 5/15/17. ACS counseled BM about filing a missing person report. On 5/22/17, ACS contacted LE who verified the 16-year-old CH's body was found. LE said the details of the investigation was confidential. ACS did not adequately explore the family's housing needs, the 14-year-old CH's possible gang involvement, the BM's current pregnancy, BF involvement and need for resources and support.

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

Issue:
Predetermination/Assessment of Current Safety and Risk

Summary:
ACS listed the history of prior abuse/maltreatment and the impact of criminal activity on the BM's ability to supervise, protect and/or care for the CHN as the safety factors. ACS identified emergency shelter and LE enforcement as safety interventions; however, the ACS did discuss how the agency monitored the safety plan.

Legal Reference:
18 NYCRR 432.1(aa)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/02/2017	Sibling, Male, 9 Years	Other Adult - Parent Substitute, Male, 34 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	Sibling, Male, 9 Years	Mother, Female, 38 Years	Educational Neglect	Unfounded	
	Sibling, Female, 7 Years	Mother, Female, 38 Years	Inadequate Guardianship	Unfounded	

Sibling, Male, 9 Years	Mother, Female, 38 Years	Inadequate Guardianship	Unfounded
Sibling, Female, 7 Years	Mother, Female, 38 Years	Inadequate Food / Clothing / Shelter	Unfounded
Sibling, Male, 9 Years	Other Adult - Parent Substitute, Male, 34 Years	Educational Neglect	Unfounded
Sibling, Female, 7 Years	Other Adult - Parent Substitute, Male, 34 Years	Educational Neglect	Unfounded
Sibling, Female, 7 Years	Other Adult - Parent Substitute, Male, 34 Years	Inadequate Food / Clothing / Shelter	Unfounded

Report Summary:
The 2/2/17 report alleged that the BM and PS did not ensure the 9-year-old CH had his eye glasses. The CH could not see and/or participate during academic instruction. BM and PS did not ensure the CH was provided with adequate sleep. The CH fell asleep during instruction and his academic progress was impacted as he was unable to perform academically. BM and PS were aware of the issues yet they failed to intervene.

The report also alleged BM and PS did not provide adequate clothing for the 7-year-old CH. The CH's clothing was too small and revealing. She was uncomfortable, in pain, and socially ostracized by her peers. The BM and PS did not take corrective action.

Determination: Unfounded | **Date of Determination:** 04/13/2017

Basis for Determination:
ACS unsubstantiated the allegations of EN, IF/C/S and IG stemming from the 2/2/17 report on the basis that the 9-year-old CH went to school with his glasses but refused to wear it during academic instructions. ACS explained that the school staff found the glasses in the CH's book bag. Regarding the 7-year-old child, ACS noted the BM said the CH was told she could not wear tight clothing. During the investigation, the 7-year-old CH dressed appropriately for school.

OCFS Review Results:
ACS staff observed the 9-year-old CH had glasses, and the 7-year-old child had school uniforms in the home. The 9-year-old said he sometimes forgot to wear his glasses. ACS did not observe the 7-year-old CH and PS until 3/22/17. ACS followed up with school staff and found the BM resolved the glasses and clothing concerns.

The family had adequate sleeping arrangements, sufficient food, and supplies. ACS staff identified the lack of family support; rent arrears, inadequate heating, and mice and roach infestation; and the 16-year-old CH's recent release from incarceration, his truancy from school and possible gang affiliation. ACS did not make a concerted effort to resolve these concerns.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
ACS inappropriately completed the RAP as the document did not reflect the case circumstances. ACS did not consider the 16-year-old CH had been in the care of family relatives prior to the 2/2/17 report, this CHN's mental health needs, school truancy and gang affiliation; and whether the BM and PS had developmentally appropriate expectations of all CHN and had attended to all CHN's needs.

Legal Reference:
18 NYCRR 432.2(d)

Action:

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
The Investigation Progress Notes were not entered contemporaneously. Some of the casework activities that occurred on 2/3/17 were entered on 4/3/17.

Legal Reference:
18 NYCRR 428.5(a) and (c)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/01/2016	Sibling, Male, 8 Years	Mother, Female, 37 Years	Lack of Supervision	Unfounded	Yes
	Sibling, Female, 9 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 9 Years	Other Adult - Parent Substitute, Male, 33 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 8 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unfounded	
	Sibling, Female, 9 Years	Mother, Female, 37 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 8 Years	Other Adult - Parent Substitute, Male, 33 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 8 Years	Other Adult - Parent Substitute, Male, 33 Years	Lack of Supervision	Unfounded	
	Sibling, Female, 9 Years	Other Adult - Parent Substitute, Male, 33 Years	Lack of Supervision	Unfounded	

Report Summary:
The 6/1/16 SCR report alleged that the CHN ages 9 years old and 8 years old were observed playing in the street without supervision. The report also alleged the CHN were outside at 9:00 PM at night. The CHN were routinely unsupervised in the street. The police had been called in the past. The BM and PS did not provide adequate supervision. The roles of the other CHN were unknown.

Determination: Unfounded | **Date of Determination:** 07/29/2016

Basis for Determination:
ACS unsubstantiated the allegations of IG and LS on the basis that the CHN were not left alone in the home. ACS explained that the CHN said they were not left alone and during many of the unannounced visits, ACS staff did not witness the children alone in the home as the BM "was always present in the home" with the CHN.

OCFS Review Results:
ACS observed and engaged the BM and seven children who resided in the home, and conducted a telephone interview

with the PS. The BM, PS and CHN denied the allegations of the report. The BM said she was unemployed and did not receive entitlements. ACS learned that the BM was unable to provide parental support to meet the CHN's academic needs. The 15-year-old CH had a 51% school attendance and he failed six classes, three due to excessive absences, and the 13-year-old and 7-year-old CHN had excessive school lateness and would not be promoted to the next grade. ACS did attempt to address the CHN's academic needs with the PS, or attempt to contact the non-custodial parents, including BF.

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

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
The 6/1/16 investigation was incomplete as ACS did not determine the family's need for resources, obtain details of the CHN's needs during the telephone interview with the PS, address the excessive school absences and lateness, and attempt to contact the non-custodial parents to determine their level of involvement with the family.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The documentation showed that the BM and CHN said the PA assisted with supervision in the home; however, ACS did not attempt to contact the PA to obtain details about her caretaker role in the family.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Face-to-Face Interview (Subject/Family)
Summary:
The ACS case record did not reflect whether there was face-to-face contact with the PS who was a subject of the 6/1/16 report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)
Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:

The RAP dated 7/5/16 did not reflect the case circumstances. The PS and his male CH were identified as members of the household composition. ACS did not assess the PS as the Secondary Caretaker in the RAP although the PS was a household member and an alleged subject of the 6/1/16 report.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

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

[redacted]

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

The Queens County Family Court (QCFC) issued a Court Ordered Investigation due to custody/visitation filing on 2/2/06. ACS conducted the investigation and submitted findings to QCFC. The QCFC determined that the BM would remain the custodial parent and the respondent father was granted visitation. ACS closed the case on 4/12/06.

The BM was known as a subject in five reports dated 12/23/10, 7/5/11, 7/30/12, 3/25/14 and 5/9/14.

The allegation of the 12/23/10 report was LS of the CH, who was then 15 months old. On 12/23/10, ACS substantiated the allegation of the report after the findings revealed the BM left the 15 month-old CH unsupervised outside of a school property. The report was indicated and closed after the family refused services.

The 7/5/11 and 7/30/12 reports included the allegations of IG and LS of five of the BM's CHN by the BM and the father of the three younger CHN. ACS unsubstantiated the allegations of the report on the basis of lack of credible evidence to support the finding of abuse/maltreatment. These two reports were unfounded and ACS referred the family for PPRS to address housing needs, history of DV concerns, child care, day care and mental health needs.

The 3/25/14 and 5/9/14 reports included the allegations of EN, IG, L/B/W and LMC by the BM. ACS unsubstantiated the allegations of the reports on the basis of lack of credible evidence gathered to support the finding of abuse/maltreatment.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 08/01/2016

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 08/01/2016

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☐	☒	☐	☐

Did the services provided meet the service needs as outlined in the case record?	☐	☒	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐
If yes, was the response appropriate to the circumstances?	☐	☒	☐	☐

Explain:
The family was evicted for their permanent home, the details of gang affiliation was not clarified, and the level of non-custodial involvement was not determined.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The most recent FASP was one day overdue as it was due on 8/31/17 and approved on 9/1/17.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☐	☐	☒	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: The case was referred for PPRS on 9/15/16.				

Required Action(s)

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	The CCNY agency did not enter Family Services Progress Notes (FSPN) contemporaneously. FSPN with entry dates of 1/25/17, 4/12/17, 4/26/17 and 6/23/17 were entered in CONNECTIONS on 5/23/17, 9/25/17, 10/2/17 and 9/14/17, respectively.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	CCNY must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. CCNY must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Adequacy of Preventive Services casework contacts
Summary:	The casework contacts did not include details about the 14-year-old CH, caretaker role of the PS and the BM supervision of the other 9-year-old male CH who was identified as the son of the PS.
Legal Reference:	18 NYCRR 423.4(c)(1)(ii)(d)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Preventive Services History

During the 7/30/12 investigation, ACS found the family needed PPRS to address DV, child care, housing and other needs. ACS opened the Family Services Stage (FSS) on 8/7/12. During the home visit with the case planner, the BM did not sign an agreement for PPRS. Subsequently, ACS closed the FSS on 10/2/12 as the BM refused services.

ACS opened an FSS on 8/1/16 to address concerns of the BM's CHN being home alone and BM taking care of her them with very limited resources. The three older CHN had a history of trauma following sexual molestation that had reportedly occurred in 2010. The Family Services Progress Notes (FSPN) showed the BM signed an agreement to accept PPRS on

9/28/16. The CCNY did not adequately address the following high risk concerns: inadequate housing condition, significant rent arrears; the BM's ability to manage the three older CHN's behavior; non-custodial fathers' involvement in supporting the family; and lack of family resources. CCNY learned of the 16-year-old child's death on 5/25/17.

CCNY did not enter progress notes contemporaneously. The casework activities that occurred on 1/27/17, 2/3/17, 3/29/17, 4/12/17, and 4/26/17 were not entered in CONNECTIONS until 5/23/17, 4/24/17, 5/23/17, 9/25/17 and 10/2/17, respectively.

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?	☒	☐	☐	☐

Foster Care Placement History

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

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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