

Report Identification Number: NY-15-016 Prepared by: New York City Regional Office

Issue Date: 10/19/2015 (Report was reissued on: 10/19/2015)

This	s 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.
X	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 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.

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Abbreviations

Relationships						
BM-Biological Mother	SM-Subject Mother	SC-Subject Child				
BF-Biological Father	SF-Subject Father	OC-Other Child				
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father				
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider				
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father				
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle				
	Contacts					
LE-Law Enforcement	CW-Case Worker	CP-Case Planner				
DrDoctor	ME-Medical Examiner	EMS-Emergency Medical Services				
DC-Day Care	FD-Fire Department	BM-Biological Mother				
CPR-Cardio-pulmonary Resuscitation						
	Allegations					
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts				
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding				
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse				
CD/A-Child's Drug/Alcohol Use	MN-Medical Neglect	EdN-Educational Neglect				
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive				
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision				
Ab-Abandonment	OTH/COI-Others					
	Miscellaneous					
IND-Indicated	UNF-Unfounded	SO-Sexual Offender				
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence				
LDSS-Local Department of Social	ACS-Administration for Children's	NYPD-New York City Police				
Service	Services	Department				
PPRS-Purchased Preventive						
Rehabilitative Services						

Case Information

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Report Type: Child Deceased **Jurisdiction:** Richmond **Date of Death:** 02/16/2015

Age: 17 year(s) Gender: Male Initial Date OCFS Notified: 02/17/2015

Presenting Information

On 2/17/15, the SCR registered a report that alleged that on 2/16/15, at approximately 1:44 A.M., the seventeen-year-old male child was shot four times and killed by an unknown assailant. The child was found dead in an apartment in Staten Island. The report also alleged the child had been dealing drugs and had pending criminal charges against him. In addition, the report alleged the mother was aware of the child's activities but had failed to provide adequate supervision of the child.

Executive Summary

This family has an extensive history of child welfare involvement dating back to 1989, with 45 SCR reports registered prior to the fatality; 7 of these reports were consolidated into ongoing investigations. There are multiple children with disabilities and there has been a multi generational pattern of chronic neglect. Additionally, there have been repeated allegations of IF/C/S, LS, EdN, SA, and DV. Some of the BM's now adult children and the SC have had involvement with LE and the criminal justice system. This family has also had lengthy periods of Court Ordered Supervision (COS).

On 2/17/15, following the receipt of the report the Specialist contacted the NYPD and the Richmond County District Attorney's Office and learned the seventeen-year-old teen died as a result of gunshot wounds to his torso. The ME deemed it a homicide. LE reported there were no drugs found in or around the apartment where the incident occurred. The SC's childhood friend was charged with his death. LE provided limited information regarding the investigation into the SC's death contrary to the protocols for joint investigations.

Between 2/17/15 and 2/19/15, the ACS Specialist made contact with the eight surviving siblings. The siblings were deemed safe; however, the school reported the children had excessive absences, multiple suspensions due to behavioral issues that resulted in the repeating of some grades. The school staff reported the BM made no efforts to comply with the Board of Education; however since ACS' involvement, the BM provided only the bare minimum required to keep the children in school. There were concerns of lack of supervision of the children as the BM was seldom at home and the older children were left to supervise the younger children.

On 2/17/15 and 2/18/15 the ACS Specialist attempted to interview the mother; however, they were not successful. ACS held a Child Safety Conference on 2/20/15 and it was decided there was a need for an Article Ten Petition of Neglect to request COS of the family. On 2/27/15, ACS filed the petition and the court granted the request for COS.

ACS continued to monitor the family through multiple home visits, contacts with the school staff, medical providers, and LE. The children's immunizations were brought up to date. Two children remained suspended for the balance of the school semester and were transferred to another school. ACS learned that the individual who allegedly shot and killed the child was located in Pennsylvania. The BM accepted services on 5/11/15 but did not attend any of the six subsequent appointments. As a response, the voluntary agency closed the referral on 6/18/15.

Following the arrest of the SC's childhood friend for the murder, the focus of the investigation turned to exploring the



information regarding the arrest of the the sixteen-year-old sibling on 3/15/15. The sixteen-year-old sibling was charged for repeatedly sexually abusing his five-year-old sibling and videotaping the acts on more than one occasion. The 16-year-old revealed that he learned this behavior from being sexually abused by the father of the 5-year-old sibling. ACS did not immediately report this information to the SCR. The five-year-old was examined and interviewed at the CAC; however, she did not disclose any information about the abuse and her tests results were negative. A full stay away order of protection against the sixteen-year-old sibling on behalf of the five-year-old took effect on 7/16/15 and expires on 7/13/25. The Richmond County Criminal Court sentenced the sixteen-year-old to six months in jail. He was released on 7/16/15 for time served and is on probation that expires on 7/13/22. He currently resides with the MGM and is the only child in the home.

On 3/19/15, the other siblings and the BM denied knowledge of the abuse. The BM agreed to counseling for the family.

ACS has not made a determination on this fatality report or the subsequent 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?No
 - Safety assessment due at the time of determination? N/A
- Was the safety decision on the approved Initial Safety Assessment No appropriate?

Determination:

 Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?

The CPS report had not yet been determined at the time this Fatality report was issued.

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

Explain:

ACS and JBCFS attempted to provide services (family therapy) to the family. A joint home visit between ACS and JBFCS was scheduled for 5/4/15; however, on 5/4/15 the family was not at home when ACS and the JBFCS representatives arrived. The BMB later informed ACS that she had forgotten about the scheduled visit. ACS and JBFCS returned to the home on 5/11/15 at which time the BM agreed to Trauma Systems therapy (TST) services; however, she later declined. The BM expressed that she wanted general preventive services, which according to ACS was inappropriate as the general preventive services would not address the trauma of the death of the child and the sexual abuse of the five year old child. As of 10/4/15 there is no documentation to indicate that the family has begun services despite the fact that this family is under court ordered supervision. The Family Services Stage remains open.

Was the decision to close the case appropriate? N/A
Was casework activity commensurate with appropriate and relevant Yes

statutory or regulatory requirements?

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

consultation.

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Explain:

This case has not been determined.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ⊠Yes □No

Issue:	Overall Completeness and Adequacy of Investigation			
Summary:	There is no documentation that the necessary collaterals were contacted, not all the children were seen in the first 24 hours after the receipt of the report, the 7-day safety assessment needed more information and the safety decision was incorrect as there were no safety issues that required a safety plan. Additionally, the children were not interviewed in detail to obtain pertinent information. Furthermore, there was almost no investigation of the fatality after the initial contacts were made with family members and LE.			
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2			
Action:	The Administration for Children's Services (ACS) must submit a corrective action plan within 45 days that identifies what action it has, or will take, to address the citation(s) 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 24 Hour Assessment			
Summary:	The 24- Hour Safeety Assessment was neither timely nor adequate as not all the children were seen within the 24-hour time frame following the receipt of the report. Additionally, the safety decision recorded on the 24-hour safety assessment did not accurately reflect the case circumstances. There were no safety factors identified that required the implementation of a safety plan.			
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)			
Action: The Administration for Children's Services must submit a corrective action plan within 45 days identifies what action it has, or will take to address the citation identified in the fatality report. must meet with the staff involved with this fatality investigation and inform NYCRO of the dat the meeting, who attended and what was discussed.				
Issue:	Mandated reporters did not report potential abuse or maltreatment of a child			
Summary:	Based on ACS' documentation, on 3/23/15, during the course of the investigation of the fatality report, a parent provided information regarding the potential sexual abuse of the sixteen-year-old child by the father of the six-year-old sibling to ACS staff in the staff's professional capacity. This information, if true, would constitute the abuse of a child. ACS staff was obligated to immediately report this information to the SCR; however, this was not done. Later, on 7/24/15, OCFS NYCRO reviewed the ACS case documentation and informed ACS of the need to make a report to the SCR regarding the alleged sexual abuse of the sixteen-year-old child. ACS did not report the information until 8/25/15. ACS did not provide any explanation for the delay in reporting this information to the SCR.			
Legal Reference:	SSL 413 and 415			
Action:	The Administration for Children's Services (ACS) must submit a corrective action plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality			

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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: 02/16/2015		Time of Death: 01:44 AM
County where fatality incide	nt occurred:	RICHMOND
Was 911 or local emergency	number called?	Yes
Time of Call:		Unknown
Did EMS to respond to the so	cene?	No
At time of incident leading to	death, had child used alco	hol or drugs? Yes
Child's activity at time of inc	ident:	
☐ Sleeping	☐ Working	☐ Driving / Vehicle occupant
☐ Playing	\square Eating	☑ Unknown
☐ Other		
Did child have supervision at circumstances	time of incident leading to	death? No - Not needed given developmental age or
Total number of deaths at in	cident event:	

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	16 Year(s)

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LDSS Response

Following the receipt of the 2/17/15 SCR report, the Specialist contacted LE and the DA's office and verified the information reported. LE reported there were no drugs found in or around the apartment where the incident occurred. Later ACS learned that a childhood friend of the SC was charged with the homicide.

The Specialist visited the home and contacted three of the surviving siblings; the others were visiting relatives. The BM told the Specialist the SC left the home at 9:00 P.M. to meet friends and cousins at a friend's home and according to the information she received from a cousin who was present at the incident, the SC began to argue with one of his childhood friends regarding who should leave the home. As the cousin went into the bathroom shots rang out and when the cousin returned the childhood friends were gone and the SC was on the floor. The BM reported the SC was not involved with gangs and had been afraid to attend school due to neighborhood gang-related conflicts.

The Specialist then interviewed the BF, who stated he was visiting to possibly relocate the SC out of state. The BF reported he saw the SC with the cousin and two male friends on their way to the friend's home and they agreed to meet later at the PGM's home. The BF stated an hour later he heard of the SC's death. ACS case documentation did not reflect the time the BF saw the SC. The BF also denied the SC's involvement with gangs or drugs; however, the BF told the Specialist the SC was known to the juvenile detention and criminal justice system.

ACS continued to monitor the family with home visits, contacts with school staff, medical providers, and LE. The children's immunizations were brought up to date. ACS made some of the necessary collateral contacts and made appropriate referrals; the BM admitted to the need for services and initiated, however; she did not follow through and later declined all services.

After the arrest of the SC's childhood friend, not much more information was obtained regarding the fatality.

On 3/15/15, the sixteen-year-old male sibling was arrested for sexually abusing his five-year-old sibling while he videotaped it on more than one occasion. A temporary order of protection was put in place. On 3/16/15, the SCR received additional information about the case. The six-year-old did not disclose any information about the abuse at the interview at the CAC. The sixteen-year-old indicated he had been abused by the sibling's father. On 3/20/15, all the other siblings were interviewed at the CAC and they all denied any knowledge of the abuse and denied being abused. ACS did not interview the sixteen-year-old sibling, and did not report this potential abuse of the sixteen-year-old to the SCR. The BM denied knowledge of the incidents and agreed to counseling for the entire family; however, she has consistently failed to comply. All children remained in the custody of the BM. The sixteen-year-old was sentenced on 6/22/15 and released to the MGM's care on 7/16/15.

Prior to the fatality report, the family had an open EdN case. The attendance tracking system for school year 2012-13 and 2014-15, indicated that of the BM's eight school aged children, seven of them were classified as emotionally disturbed or learning disabled. They were enrolled in special education classes and had been receiving counseling. The children had excessive absences, multiple suspensions due to behavioral issues, and incomplete immunizations that resulted in repeated grades. The youngest school age child was chronically absent and late. The school staff reported the BM made no efforts to comply with the Board of Education rules which caused the children's suspensions and there were concerns for the children's supervision in the home.

This case has not been determined.

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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)?No

Comments: The ACS investigation did not adhere to previously approved protocols for joint investigation. Law

Enforcement did not share information with ACS in a timely manner.

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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
014781 - Deceased Child, Male, 17	014782 - Mother, Female, 41	Lack of Supervision	Pending
Yrs	Year(s)		
014781 - Deceased Child, Male, 17	014782 - Mother, Female, 41	Inadequate	Pending
Yrs	Year(s)	Guardianship	
014781 - Deceased Child, Male, 17	014782 - Mother, Female, 41	DOA / Fatality	Pending
Yrs	Year(s)		

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?		X		
Other				X
Was a death-scene investigation performed?	×			
Was there discussion with all parties (youth, other household	×			

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members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?				
Coordination of investigation with law enforcement?	×			
Did the investigation adhere to established protocols for a joint investigation?		X		
Was there timely entry of progress notes and other required documentation?	×			
Additional information: Documentation was timely and ACS made effort to obtain and document th large family. While the children were seen between 2/17/15 and 2/19/15, the maintained contact with the sixteen-year-old child who was incarcerated for	ne document	ation did no	ot reflect that	t ACS
Fatality Safety Assessment Activi	ities			
	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 of in the household named in the report:	langer to su	irviving sib	lings/other	children
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?		X		
Are there any safety issues that need to be referred back to the local district?		X		
	Γ		T	I
When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	×			
Fatality Risk Assessment / Risk Assessm	ent Profile			
	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?			X	
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the		X		

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household?								
Was there ar	adequate assessment of the family's need	s? ×						
_	ective factors in this case require the LDS amily Court at any time during or after the?	×						
Were approp	oriate/needed services offered in this case		×					
			•		·			
	Placement Activities in Res	sponse to the F	atality Investig	ation				
	1 100 110 110 110 110 110 110 110 110 1	pointe to the I			_	_		
			Yes	No	N/A	Unable to Determine		
siblings/other	y factors in the case show the need for the r children in the household be removed ar t any time during this fatality investigation	nd placed in		X				
	urviving siblings/other children in the hou result of this fatality report/investigation			×				
	Legal Activity	Related to the	Fatality					
Was there leg ⊠Family Cou	gal activity as a result of the fatality invest art Criminal Cour	_	図(Order of Prot	ection			
Family Cour	t Petition Type: FCA Article 10 - CPS							
Date Filed:	Fact Finding Description:]	Disposition De	escription:				
02/27/2015	There was not a fact finding	A	Adjourned					
Respondent:	014782 Mother Female 41 Year(s)							
Comments:	ACS recommended that the children be par Care Management for the family and for the along with attending school meetings. The	e BM to follo	ow-through wi	th immuniza	tions for the	children		
Criminal Cha	arge: Murder Degree: 1				1			
Date Charges Filed:	Against Whom?	Date of Di	sposition:		Disposition	1:		
Unknown	The SC's childhood friend	Unknown			Unknown			
Comments:								

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Have any Orders of Protection been issued? Yes	
From: Unknown To: Unkn	own

Services Provided to the Family in Response to the Fatality

	Provided	Offered,	Offered,	Needed	Needed		CDR
Services	After	but	Unknown	but not	but	N/A	Lead to
Scrvices	Death	Refused	if Used		Unavaliable	IVA	Referral
Bereavement counseling		X					
Economic support						×	
Funeral arrangements	×						
Housing assistance						×	
Mental health services		X					
Foster care						×	
Health care						×	
Legal services						×	
Family planning						×	
Homemaking Services		X					
Parenting Skills						×	
Domestic Violence Services						×	
Early Intervention		X					
Alcohol/Substance abuse						\boxtimes	
Child Care						\boxtimes	
Intensive case management		X					
Family or others as safety resources						×	
Other						×	

Additional information, if necessary:

The appropriate services were recommended and the family completed the intake process with JBFCS on 5/15/15. The BM missed four consecutive appointments and on 6/18/15, the agency staff notified the Specialist that the case was rejected due to BM's unavailability. On 7/16/15, the BM requested a general preventive service plan through the community. ACS deemed the plan inappropriate to address the trauma of the child's death and the sexual abuse the younger sibling experienced. ACS made the referral but there is an ongoing pattern of the BM's unwillingness to follow through with services she admitted the children needed. ACS provided clothing to the family.

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? No

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Explain:

ACS provided PPRS Case Management services for the entire family. The BM accepted therapy and bereavement counseling for the family. A joint visit with the service agency was completed on 5/11/15; however, on 7/16/15, the BM declined Trauma Systems Therapy services and has not engaged in general preventive services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

The BM accepted bereavement counseling and therapy; however, the agency rejected the case because the BM missed six appointments then declined the services. Although the BM admitted the children needed specific services to address the trauma and abuse, and was court ordered to comply with services, she refused the appropriate services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Was there an open CPS case with this child at the time of death? No Was the child ever placed outside of the home prior to the death? No Were there any siblings ever placed outside of the home prior to this child's death? Yes 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)
04/23/2012	4285 - Sibling, Female, 10 Years	4281 - Mother, Female, 38 Years	Inadequate Guardianship	Indicated	No
	5011 - Sibling, Male, 9 Years	4281 - Mother, Female, 38 Years	Inadequate Guardianship	Indicated	

Report Summary:

On 4/23/12, the SCR registered a report that alleged Inadequate Guardianship of the then nine and ten-year-old children by the BM. The children were not allowed to go home on the school bus because they were suspended for fighting and cursing the bus driver earlier that day. The report alleged there were many attempts to reach the BM who did not answer her cell phone until 4:30 P.M. She was then asked to pick up the children. At 5:30 P.M., the thirteen-year-old sibling arrived at the school to accompany the children home but the school did not release them because he was not authorized to pick them up. The then fourteen-year-old SC was scheduled to pick up his siblings; however, he forgot he had a court appearance on the same day and could not therefore get his siblings. The police were contacted and they transported the children to their home. The report also alleged that the BM failed to make a viable plan for the care of the children.

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At the time of the SCR report, there were 10 minor children in the home. Two of the school aged children, the nine and ten-year-old, were suspended from school for fighting and using profane language towards the bus driver. The school had to hire an assistant to travel on the bus with the children because of their behavior. According to ACS case documentation, the BM and older children reported the arrangement was for the then fourteen-year-old child to pick up the children from school, but he forgot he had to report to family court. The BM then chose to send the thirteen-year-old sibling, in a taxi, to pick the children up and to return in the taxi; however the school did not release the children to the sibling. ACS' investigation revealed that the Assistant Principal explained that school policy states a minor cannot sign another minor out of school and cannot be on the contact card maintained by schools for emergencies. The BM expressed her displeasure with the school and the frustration regarding the frequent calls and complaints from the school staff.

The home was observed to have adequate food, clothing and sleep arrangements. The Specialist found no safety concerns and no significant other in the home. During this investigation, the BM received a mental health evaluation which reflected no clinical illnesses. The investigation also revealed the SC who was facing criminal charges, had become quiet and withdrawn. The nine and ten-year-old children were suspended from school. The BM did not attend the superintendent suspension meeting; however, she later contacted the school and plead no contest. The BM reported feeling frustrated about the frequent calls from the school regarding her children.

Determination: Indicated **Date of Determination:** 05/12/2012

Basis for Determination:

On 5/16/12, ACS substantiated the allegation of the report on the basis citing credible evidence the BM failed to establish a plan for the children to be picked up from school by an adult.

OCFS Review Results:

On 6/8/12 an End of Order report was submitted to Richmond County Family Court. The report noted the family was doing well in spite of the children's suspension from school, the BM's frustration with court and school. These were indications the BM was overwhelmed and ACS did not capture this in their report to Richmond County Family Court. The investigation determination safety assessment did not reflect the circumstances in the home. ACS had an opportunity to file a continuance of supervision for the family but did not do so. The court ordered supervision ended on 8/8/12.

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)
11/07/2012	4291 - Sibling, Male, 10 Years	4294 - Mother, Female, 38 Years	Inadequate Food / Clothing / Shelter	Unfounded	No
	4293 - Sibling, Female, 11 Years	4294 - Mother, Female, 38 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:

On 11/7/12, the SCR registered a report that alleged the then eight, ten and eleven-year-old children were inappropriately dressed for school and the weather. The report noted this was an ongoing issue and the BM stated that the eleven-year-old SC should be responsible for choosing her own clothing. The report alleged an ongoing problem with the children being under-dressed for the weather conditions. The allegation of that report was IF/C/S of the eleven, ten and eight-year-old children by the BM.

The investigation revealed that the eleven-year-old child wore shorts to school and when informed, the BM stated the child did not leave home dressed in shorts; however, her daughter's behavior was typical for her age. She also explained that the children would not be exposed to the weather because they were on the school bus. The BM expressed concern for her children's progress in school; however, she did not attend a scheduled school meeting stating the school staff were "racist."

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On 12/31/12, the allegation of IF/C/S was unsubstantiated and the BM declined preventive services. The case was unfounded and closed.

Determination: Unfounded **Date of Determination:** 12/31/2012

Basis for Determination:

The three children stated that the eleven-year-old was appropriately dressed when she left home but later removed her sweat pants. The ten and eight-year-old children had jackets for the cold weather but chose not to wear them because they wore heavy sweaters and rode on the school bus; therefore they were not exposed to the elements of the weather.

OCFS Review Results:

The decision by ACS to unfound the report did not address the issue of adequate supervision of the children by the BM. The children may have had sufficient clothing but required supervision in addition to the appropriate attire. During the investigations of these reports ACS treated each report as a separate incident.

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)	
	03/14/2013	3372 - Sibling, Male, 7	3363 - Mother, Female, 39	Educational	Indicated	Yes	
03/14/2013	Years	Years	Neglect	mulcated	1 68		

Report Summary:

The 3/14/13 report alleged EdN of the seven-year-old child by the BM. It was reported that the child had missed 36 days of school and was late several times and failing as a result. The BM had been contacted but had not responded; she failed to cooperate.

ACS investigation revealed the child was in need of an IEP and the mother failed to complete the process until ACS' involvement. The BM stated she did everything the school asked her to do and that they were being a nuisance. The child had an in-house suspension and the mother kept him home stating he was sick. After ACS' involvement, the BM agreed to attend all necessary appointments regarding the child's education. The behavior of the SC in this report needed improvement; he was scheduled to attend therapy at school but was frequently absent. ACS also learned that the fourteen-year-old child's attendance was poor and he was in danger of repeating that grade for the second time. However, ACS did not add EdN to this report for this child although there was justification to add the allegation.

During this investigation, the eight-year-old child's father filed for custody and received visitation with the child. The school reported the child's attendance, academic performance had improved and when he came to school from the father's home, he was appropriately dressed and clean.

Determination: Indicated **Date of Determination:** 05/13/2013

Basis for Determination:

ACS found credible evidence citing that the seven-year-old child had numerous absences for the 2012-2013 school year. The child would be held over to repeat 1st grade. The BM had not taken a proactive role in meeting the child's educational needs until ACS' involvement. The BM was instructed to attend all necessary meetings at the school regarding the child's IEP for counseling. The BM completed the process for the IEP and the child's attendance had improved. Since the report allegations, the child's BF has been actively involved with the child and he has been attending school meetings. The BM declined PPRS services and was provided with community based organization referrals.

OCFS Review Results:

As a result of the report, the BF became involved in the child's education. ACS documented that the fourteen-year-old child also had poor attendance. ACS stated although the case was a chronic neglect case, the BM appeared to have been

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minimally meeting the needs of the children at that time. The Specialist did not document the circumstances of the case in the safety assessment and RAP.

Are there Required Actions related to the compliance issue(s)? \boxtimes Yes \square No

Issue:

Appropriateness of allegation determination

Summary:

ACS had information to support the addition and substantiation of the allegation of EdN of the fourteen-year-old child by the mother. The child was failing academically because of excessive absences; however, the allegation was not added to the report.

Legal Reference:

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

Action:

The Administration for Children's Services must submit a corrective action plan within 45 days that identifies what action it has, or will take to address the citation 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)
09/16/2013	3353 - Sibling, Male, 7 Years	3352 - Mother, Female, 40 Years	Inadequate Guardianship	Indicated	No
	3353 - Sibling, Male, 7 Years	3352 - Mother, Female, 40 Years	Lack of Supervision	Indicated	
	3355 - Sibling, Male, 15 Years	3352 - Mother, Female, 40 Years	Inadequate Guardianship	Indicated	
	3355 - Sibling, Male, 15 Years	3352 - Mother, Female, 40 Years	Lack of Supervision	Indicated	
	3358 - Sibling, Male, 10 Years	3352 - Mother, Female, 40 Years	Inadequate Guardianship	Indicated	
	3358 - Sibling, Male, 10 Years	3352 - Mother, Female, 40 Years	Lack of Supervision	Indicated	
	3375 - Sibling, Female, 11 Years	3352 - Mother, Female, 40 Years	Inadequate Guardianship	Indicated	
	3375 - Sibling, Female, 11 Years	3352 - Mother, Female, 40 Years	Lack of Supervision	Indicated	
	3377 - Sibling, Male, 9 Years	3352 - Mother, Female, 40 Years	Inadequate Guardianship	Indicated	
	3377 - Sibling, Male, 9 Years	3352 - Mother, Female, 40 Years	Lack of Supervision	Indicated	
	3376 - Sibling, Female, 3 Years	3352 - Mother, Female, 40 Years	Lack of Supervision	Indicated	

Report Summary:

The 9/16/13 report alleged the BM was sometimes late in picking up the then nine, ten and eleven-year-old children from school and that she had no provisions for them. The report added that the children were often unprepared, improperly clothed and had a pattern of missing school. On 9/27/13, the SCR registered two subsequent reports alleging the children

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were home alone with no supervision and they engaged in altercations with other children in the neighborhood. These intake reports with similar allegations were merged into the open 9/16/13 investigation.

The ACS' investigation revealed the children were often unsupervised and engaged in altercations with other children in the neighborhood. The police had been called to the home on several occasions due to the children's vulgarity and menacing with both adults and children in the neighborhood.

Determination: Indicated **Date of Determination:** 11/13/2013

Basis for Determination:

ACS found credible evidence to substantiate the allegation. ACS wrote that the BM failed to pick up the children up from school on time or make arrangements for them to be picked up in a timely manner. The BM failed to obtain doctor's notes to have bus reinstated for the children. The children were suspended and the BM failed to take them to their suspension sites because it was "inconvenient to get them to three different schools." The older children were often tasked with watching the younger children while the BM was out and they were involved in an argument at the bus stop.

OCFS Review Results:

ACS assisted the BM in obtaining bus service for the children. BM has refused all services stating that "no one can help her." This case required a higher level of intervention; it does not appear that the intervention chosen by ACS was appropriate at this juncture.

Are there Required Actions related to the compliance issue(s)? □Yes ⊠No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/08/2014	3380 - Sibling, Male, 15 Years	3379 - Mother, Female, 40 Years	Educational Neglect	Indicated	No

Report Summary:

The 5/8/14 report alleged EdN of the then fifteen-year-old child by the BM. The report stated the then fifteen-year-old child had a history of truancy (100 days last year) and this year, 2014. The SC missed an excessive amount of school (90 days). As a result, he was failing academically as he had in 2013, was deemed a truant and the BM did nothing to ensure the child attended school regularly.

The investigation revealed that on 6/15/13, the SC was arrested and charged with assault, attempted murder and possession of a loaded firearm. He was arrested on 12/16/13 and charged with criminal mischief; he was released on bail. The ATS school system reflected the SC enrolled in Passages Academy in the Bronx Juvenile Facility on 4/23/14. His next court date was 5/19/14.

Determination: Indicated **Date of Determination:** 06/25/2014

Basis for Determination:

ACS found credible evidence to substantiate the allegation of EdN against the BM. ACS wrote that the child stated he was afraid to attend school due to fights between teenagers, however, he refused to file a police report.

OCFS Review Results:

ACS offered assistance to have the child transfer to another school but the BM did not follow through stating she was considering whether the child should work or live with his father in another borough. ACS referred the family to services but the mother declined all offers. Again ACS could have at this juncture petitioned Family Court for judicial intervention; however, there was no documentation to suggest it was considered.

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

Date of SCR	Alleged	Alleged	Allegation(s)	Status/Outcome	Compliance

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Report	Victim(s)	Perpetrator(s)			Issue(s)
02/10/2015	3388 - Deceased Child, Male, 17 Years	3389 - Mother, Female, 41 Years	Educational Neglect	Indicated	No
	3390 - Sibling, Male, 16 Years	3389 - Mother, Female, 41 Years	Educational Neglect	Indicated	
	3391 - Sibling, Female, 14 Years	3389 - Mother, Female, 41 Years	Educational Neglect	Indicated	
	3392 - Sibling, Female, 13 Years	3389 - Mother, Female, 41 Years	Educational Neglect	Indicated	
	3393 - Sibling, Male, 12 Years	3389 - Mother, Female, 41 Years	Educational Neglect	Indicated	
	3394 - Sibling, Male, 11 Years	3389 - Mother, Female, 41 Years	Educational Neglect	Indicated	
	3395 - Sibling, Male, 8 Years	3389 - Mother, Female, 41 Years	Educational Neglect	Indicated	
	3396 - Sibling, Female, 5 Years	3389 - Mother, Female, 41 Years	Educational Neglect	Indicated	
	3388 - Deceased Child, Male, 17 Years	3389 - Mother, Female, 41 Years	Lack of Supervision	Unfounded	

Report Summary:

The 2/10/15 report narrative alleged that the BM failed to have the fourteen, thirteen, and twelve-year-old children immunized as required by the school. As a result, the children had been excluded from school and are at risk of failing. The report added that the thirteen and twelve-year-old children are on superintendent suspension and are placed at a suspension site.

During the investigation, ACS added EdN of the seventeen, sixteen, fourteen, thirteen, twelve, eleven, eight and five-year-old children; and on 4/22/15, all were substantiated.

The LS of the seventeen-year-old child by the BM was also added; however, the allegation was unsubstantiated.

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

Basis for Determination:

ACS cited the children's schools records for each child and they reflected chronic absenteeism that resulted in repeated grades for some children. ACS wrote the BM did not attend any of the children's suspension meetings, parent teacher conferences, address notices sent home and did not communicate effectively. On 2/27/15, ACS filed an Article Ten against the BM on behalf of the children and COS was granted. ACS referred the family for services. The case remained open for services.

The LS allegation of the seventeen-year-old by the BM was unsubstantiated. ACS wrote that the teen was killed by another person while he was at a friend's house where the BF was supposed to have been visiting.

OCFS Review Results:

ACS took appropriate action by filing the Article Ten Neglect Petition to obtain COS.

Are there Required Actions related to the compliance issue(s)? $\square Yes \square No$

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



This family has been known to the SCR and to ACS since 1989. The BM had fourteen children and between 11/30/89 and 12/23/11, there have been thirty-one CPS investigations that named the BM as a subject of the reports. Twenty-two of these reports were indicated against the BM. The allegations of these reports were consistently IF/C/S, EdN, LS, LMC and IG of the children by the BM. There was a continual, overall concern regarding the children's educational needs, inadequate housing conditions, IG and neglect. ACS documented the difficulty in engaging the BM in any services. Throughout the cases, the BM established a pattern where she would initially accept services then decline them.

The 1/21/11 report alleged that the BM did not have a stable address and was unable to meet the children's basic needs. The report also alleged that the BM threw her sixteen-month-old child off the sofa and the child sustained a fractured arm. The allegations were IG, IF/C/S of all the children and FX of the then sixteen-month-old child by the BM.

The ACS investigation revealed that at the time, the children resided with the MGM while the BM searched for a new apartment. The MGM reported that she was the primary caretaker while the BM resided elsewhere and only helped out on occasion and the MGM said she was frustrated with the arrangement. The MGM reported the children mimicked the BM's attitude and were rude and disrespectful. In 11/10, the sixteen-month-old child, who did not have a crib, was jumping on the sofa and fell off resulting in a fractured left collar bone. It was reported that the child received medical care from St. Vincent's Hospital. The BM refused to sign a medical consent release form. The children all stated the BM was not present at the time of the incident. The allegation against the BM was unfounded. The MGM acknowledged the children's lateness and absences and explained that she transported the children to five different schools. The BM secured a new apartment and those children that were eligible were bussed to school. On 3/09/11, ACS unsubstantiated the allegations of the report.

On 4/6/11, ACS received an order for a Court Ordered Investigation (COI) from Richmond County Family Court. The BF of the then five-year-old child filed a petition seeking visitation. The BF stated the BM refused him access to the child since the child's birth. The BF also requested and obtained an OOP against the BM citing harassment. The COI investigation revealed the now deceased child's behavior was out of control and he was suspended from school for attacking a student and a teacher. As a result, the SC and his older brother (now adult) were suspended from school. The BM failed to show up for the suspension hearing. ACS supplied beds for the children.

On 7/25/11, the SCR registered a report the then one-year-old child had sustained 2nd degree burns. On the same date, ACS filed an Article Ten Neglect petition in Richmond County Family Court. On 8/2/11, the then one and five-year-old children were remanded into protective custody and the eight older siblings remained in the home with the BM with ACS Supervision. The one-year-old child was placed into foster care with her PGF. On 8/8/11, the five-year-old was discharged from the hospital and placed into a non kinship foster home until 10/23/11, when she was replaced into a different foster home. In 12/11, the five and eight-year old children's case was transferred to the New York Foundling agency and the siblings were reunited and placed into the home of the MGM and MGF until they were released from FC to the BM on 2/9/12 with six months supervision by ACS. ACS was ordered to make visits to the BM's home twice weekly; however, the BM became resistant and was often unavailable

On 8/12/11, the SCR registered a report that alleged the SC had been assaulted by BF as a form of discipline. ACS' investigation revealed the incident did occur.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Services Open at the Time of the Fatality

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Required Action(s)

1								
Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ? □Yes ⊠No								
Preventive Services History								
There is no record of Preventive Services History provided to the deceased other children residing in the deceased child's household at the time of the f		eceased chil	d's siblings	s, and/or the				
Casework Contacts								
	Yes	No	N/A	Unable to Determine				
Were face-to-face contacts with the child in the child's placement location made with the required frequency?		×						
Required Action(s)								
Are there Required Actions related to the compliance issues for provisi ☐Yes ☑No	on of Foste	r Care Ser	vices?					

Foster Care Placement History

According to ACS' case documentation, ACS filed an Article Ten Neglect Petition in Richmond County Family Court (RCFC) on behalf of two now adult children against the BM for IG, M/FTTH and LMC. The allegations were substantiated against the BM. Those two children were placed in foster care and on 10/15/1992, after his birth, the BM's third son also entered foster care. On 6/10/1997, the three children were final discharged to the BM. On 5/19/1998, an Article Ten Petition was filed in RCFC against the BM for EdN and LMC of the children and COS was granted.

An Article Ten Neglect petition was again filed on 10/4/06 following a report of EdN of the school aged children. The children were parolled to the BM with COS. On 5/18/07, the BM entered a plea of admission of the allegations and the judge returned the school aged children to her with ACS supervision for six months. The children were placed with the PGM who filed for custody but was denied.

On 7/28/11, ACS filed an Article Ten Neglect Petition in Richmond County Family Court on behalf of the now eight and five-year-old children by the BM and an adult sibling. The now five-year-old child sustained 2nd Degree burns while in the care of an adult sibling who was not an adequate caretaker.

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On 2/9/12, those children were placed with the MGM under the auspices of the Seaman's Society agency and all other children remained in the home with ACS' supervision.

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