Child Fatality Report

Report Identification Number: NY-16-088

Prepared by: New York City Regional Office

Issue Date: Mar 21, 2017

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

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

Case Information

Report Type: Child Deceased
Age: 9 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 08/19/2016
Initial Date OCFS Notified: 08/19/2016

Presenting Information

The 8/19/16 report alleged that on 8/19/16, the 9-year-old SC was left home alone for an undetermined period of time during which she died. At an unknown time, the unrelated home member returned to the home and discovered that the bathroom door was locked and the SC was not responding to attempts at communication. The unrelated home member ran to seek help and another individual entered the home and kicked down the bathroom door where the SC was found. The SC was face down in the bathtub and was unresponsive. There was no standing water in the bathtub and the faucet was not running. Emergency Services were contacted at about 5:59 PM. When emergency services arrived to the home, the SC's body was naked, wet, and there was shampoo in her hair. Rigor mortis and lividity set in and the SC had a marble sized swollen bump over her right eyebrow. There were no other visible injuries. The SC was pronounced dead at 6:07 PM. and there was currently no determined cause of death.

Executive Summary

The 9-year-old female child (SC) died on 8/19/16. The ME verbally informed ACS that the cause of death was listed as strangulation and the manner of death as homicide.

The allegations of the 8/19/16 report were DOA/Fatality, IG, LS, and S/D/S of the SC by the stepmother (STM), SF, and two Unrelated Home Members (UHM). A subsequent report was registered on 8/19/16. The allegations were DOA/Fatality, IG, and L/B/W of the SC by the STM. STM for the SC was the MGM for the 3-year-old and 5-year-old children.

ACS learned that according to LE, the UHM found the SC in the bathroom. The UHM reported that at about 3:00 PM, she asked the STM about the SC as she had not seen her all day. The STM told her the SC was in the bathroom taking a shower. After about two hours she saw the SC appeared to be in the bathroom and when she did not hear any noise, she knocked on the door and received no response. The UHM said she contacted the SF who advised that she take down the door. The UHM said she attempted to open the door but the door remained locked. The UHM contacted her sibling who came and forcefully opened the bathroom door. The SC was found in the bathtub motionless and nude with shampoo on her hair, and no water in the tub. The UHM’s sibling called 911. The SF was at work. He came home shortly later and he passed out when informed about the SC’s death. The STM was arrested at another address and was charged with homicide. The STM and the 3-year-old and 5-year-old children were picked up at the STM’s former spouses home. Emergency services was contacted at about 5:59 PM.

On 8/20/16, the BM said she had asked the STM to care for her two children. She said she did not surrender her parental rights. The STM had been taking care of the children since birth. On 8/20/16, ACS removed the two children from the STM’s care as she had been the primary caretaker. The children were placed in foster care with the Forestdale, Inc. agency.

On 8/25/16, the ME said the SC had marks on her neck. She had contusions, cuts/lacerations on her mouth and feet indicative of a struggle. The contusions indicted there was blunt impact to the body. The SC had contusions to her scalp and a bruise above the right eyebrow. The ME could not provide a time of death.

On 8/25/16, an Article Ten Petition was filed in the Queens County Family Court (QCFC) naming the STM, BM, and BF of the 3-year-old and 5-year-old children as the respondents.

On 12/12/16, ACS Sub the allegations of DOA/Fatality, S/D/S, LS, and IG by the STM, and IG by the SF. ACS based the determination on the findings that the SC was in the care of the STM at the time of her death and was found to be strangled, and left in the bath tub. The STM was incarcerated as she was charged with second degree murder. It was reported that the cause of death was strangulation. The SC was left alone in the bathroom with no supervision for an extended period of time, and was found in the bathroom with swelling and lacerations to her body. The STM did not provide the minimum degree of care to the SC. The SF left the SC in the care of the STM despite having been allegedly told she would kill the child. The SF did not ensure the safety and well-being of the SC.

ACS Unsub the allegations of DOA/Fatality, IG, LS, and S/D/S by the UHM and UHM2, and DOA/Fatality, LS, and S/D/S by the SF. There was no credible evidence to support that the two UHMs had caretaker responsibility or inflicted harm which caused the death of the SC. There was no credible evidence to support the allegation against the SF whereas the SC was not in his care at the time she was strangled and killed. There was no credible evidence to support the SC's injury was inflicted by the SF. The SF did not have caretaker responsibility nor was he legally responsible for the SC at the time of her death. He entrusted the care of the SC to the STM. ACS Sub the allegations of the 8/19/16 SCR Subsequent report by the STM.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
NA

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The documentation did not reflect that the UHM's relative was interviewed regarding the incident as he helped in opening the bathroom door.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a corrective action plan 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:	Failure to provide notice of report
Summary:	The CONNECTIONS Event List did not reflect that ACS provided the BM of the 3-year-old and 5-year-old children and the UHM the Notice of Existence of the 8/19/16 report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan 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: 08/19/2016 **Time of Death:** 06:07 PM

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

County where fatality incident occurred: QUEENS
Was 911 or local emergency number called? Yes
Time of Call: 05:59 PM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: taking shower/bath

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not

impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	9 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	44 Year(s)
Deceased Child's Household	Other Child	No Role	Female	3 Year(s)
Deceased Child's Household	Other Child	No Role	Female	5 Year(s)
Deceased Child's Household	Other Child	No Role	Female	3 Year(s)
Deceased Child's Household	Other Child	No Role	Male	3 Year(s)
Deceased Child's Household	Stepmother	Alleged Perpetrator	Female	55 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	36 Year(s)
Other Household 1	Other Adult	No Role	Female	27 Year(s)

LDSS Response

On 8/20/16, the UHM reported that the STM and SF shared an apartment with them (UHM's). The UHM's family slept in one bedroom and the STM and SF slept in another. They had separate bathrooms. The family moved into the apartment on 8/3/16. The UHM said the only interaction she had with the family was to discuss the utility bill. The UHM said that on 8/19/16, she observed the bathroom light was on in the other bedroom. She told the STM to turn off the light if they were not using the bathroom and reminded her of the utility bill. At about 3:00 PM, the STM, accompanied by her two grandchildren prepared to leave the case address. The UHM asked the STM why the bathroom light was on. The STM told her the SC was in the bathroom washing her hair and she did not want the STM's help; the SC wanted to wait for the SF. The UHM was told that the SF would be home soon. The UHM observed the bathroom light was still on, she knocked on the bathroom door but received no response. She attempted to open the door but it was locked. At about 5:45 PM, the UHM called UHM2 who contacted his cousin. The cousin came to the home and kicked the bathroom door in and observed the SC's body was in the bathtub.

Later, the UHM said she called the SF and he asked her to knock on the door. She knocked and listened for noise, but did not hear any sound. The SF became upset and asked that she open the door. She contacted her sibling to help her get the door open as the UHM2 was not at home. Her sibling came and knocked the door down. She saw the SC lying in the bathtub: the SC not moving. She told the SF and her sibling called 911. The UHM said her children were in the room playing and did not observe the SC in the bathtub.

On 9/6/16, the SF reported that the STM had been commenting about the SF spending too much time with the SC. He said the STM made a comment about her intention to kill the SC. Due to her comment, he allowed the SC to spend time with relatives up until a week before her death. The STM stated it was not necessary as she could care for the SC. The SF said on 8/17/16 the STM went to Family Court for her two grandchildren. He spoke with her throughout the day and she inquired about the SC's whereabouts. He told her she was with a cousin. When she got home, she asked about the SC, but

the SF told her it was too late in the evening. The SF said the STM expressed how sorry she was and explained that she would never do anything to hurt the SC. He trusted her as she was his spouse so he called his cousin and asked him to bring the SC home on 8/18/16 which the cousin did, and everything seemed fine. On the morning of 8/19/16, the SF said he went to work and called her when he got there. At that time, the STM said she was eating and the children were sleeping. He said he called the STM two other times during the day at 11:30 AM and 3:30 PM. When he called at 3:30 PM, the STM said the SC was in the bathroom taking a shower. He received a call from his friend's sister at 5:41 PM telling him the STM had left and she did not see the SC. He said she further told him the light was on in the bathroom and she did not see the SC exit the bathroom. He asked her to look around the home and knock on the door but she said she did not see her or hear any noise in the bathroom. He said he asked her to knock the door down. He stated his friend broke down the door.

On 10/21/16, the STM informed ACS that due to her pending criminal case she did not want to discuss the reported concerns. She denied what was being reported against her. She said she would never do anything to harm the three children. The STM said she did not really know what occurred the day of the incident. Documentation reflected that ACS inquired of the STM why she did not take the SC with her when she left. The STM said that this was not new, and when she ran errands with her former spouse, she only took her grandchildren. She said the SF would tell her to leave the SC with the tenants.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical 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 investigation adhered to previously approved protocols for joint investigations.

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.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
034959 - Deceased Child, Female, 9 Yrs	034961 - Unrelated Home Member, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034960 - Unrelated Home Member, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034962 - Father, Male, 44 Year(s)	Lack of Supervision	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034962 - Father, Male, 44 Year(s)	Swelling / Dislocations / Sprains	Unsubstantiated

034959 - Deceased Child, Female, 9 Yrs	034963 - Stepmother, Female, 55 Year(s)	Swelling / Dislocations / Sprains	Substantiated
034959 - Deceased Child, Female, 9 Yrs	034963 - Stepmother, Female, 55 Year(s)	Lacerations / Bruises / Welts	Substantiated
034959 - Deceased Child, Female, 9 Yrs	034963 - Stepmother, Female, 55 Year(s)	DOA / Fatality	Substantiated
034959 - Deceased Child, Female, 9 Yrs	034963 - Stepmother, Female, 55 Year(s)	Inadequate Guardianship	Substantiated
034959 - Deceased Child, Female, 9 Yrs	034962 - Father, Male, 44 Year(s)	DOA / Fatality	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034960 - Unrelated Home Member, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034961 - Unrelated Home Member, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034960 - Unrelated Home Member, Female, 27 Year(s)	Swelling / Dislocations / Sprains	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034963 - Stepmother, Female, 55 Year(s)	Lack of Supervision	Substantiated
034959 - Deceased Child, Female, 9 Yrs	034960 - Unrelated Home Member, Female, 27 Year(s)	Lack of Supervision	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034962 - Father, Male, 44 Year(s)	Inadequate Guardianship	Substantiated
034959 - Deceased Child, Female, 9 Yrs	034961 - Unrelated Home Member, Male, 36 Year(s)	Lack of Supervision	Unsubstantiated
034959 - Deceased Child, Female, 9 Yrs	034961 - Unrelated Home Member, Male, 36 Year(s)	Swelling / Dislocations / Sprains	Unsubstantiated

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?	☐	☒	☐	☐
School	☐	☒	☐	☐
Pediatrician	☐	☐	☐	☒
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household	☒	☐	☐	☐

members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?				
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The STM,who was incarcerated, was interviewed by telephone. On 8/25/16, ACS contacted the SC's school but was unsuccessful. ACS was able to retrieve her attendance report.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐

Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☒	☐	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☒	☐	☐	☐
If Yes, court ordered?	☐	☒	☐	☐

Explain as necessary:
The 8/20/16 safety assessment reflected that on 8/19/16 the SC was found deceased in the bathtub in the home. The SC was in the care of the STM. The STM of the SC was the primary caretaker of her grandchildren (the 3-year-old and 5-year-old children). The two children were removed from her care and placed into foster care.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☒Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
08/25/2016	There was not a fact finding	There was not a disposition
Respondent:	034963 Stepmother Female 55 Year(s)	
Comments:	The documentation reflected that on 8/22/16, the BM and BF of the two children went to the ACS office seeking their children be released to the care of the BF. They both indicated there was a pending custody court case; however, they were willing to work together as opposed to having the children placed in foster care. The BM said she was in no condition to resume caring responsibility of the children as she said she was pregnant and the MGM (STM to SC) was the primary caretaker. On 8/25/16, an Article Ten Abuse Petition was filed in Queens County Family Court naming the STM, and birth parents of the 3-year-old and 5-year-old children as the respondents. On the same day, a meeting occurred. ACS documented the service plan for the BM, BF and the two children. Later, the two children were returned to the BF with ACS supervision. The BF was required to comply with drug/alcohol assessment, random drug and alcohol screening. There was also an order of protection (OOP) that he must not be under the influence of drugs and alcohol while caring for the two children. He was also directed to comply with supervised visitation for the BM.	

Criminal Charge: Murder	**Degree:** 2		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	Stepmother	Unknown	Unknown
Comments:	The STM was charged with second degree murder.		

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
The documentation reflected the service plan for the BM of the 3-year-old and 5-year-old children was DV counseling, parenting skills, individual counseling, and a clinical health assessment. The BF of the 3-year-old and 5-year-old children was referred for parenting program, individual counseling, and batterer's counseling. The two children was scheduled for EI referral and counseling.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The 3-year-old and 5-year-old children of the STM (MGM) were removed from her care and placed into foster care with the Forestdale, Inc. agency.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The STM was incarcerated at a facility. The SF of the SC declined bereavement counseling. The BF of the 3-year-old and 5-year-old children was provided with PPRS in Nassau County. The UHMs declined services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
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?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

The STM was known as a subject in one report dated 10/14/04. The allegations of report were IG and L/B/W. On 12/9/04, the report was IND. The SF and both UHMs were not known to the SCR or ACS as a subject.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Required Action(s)

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

Issue:	Adequacy of Progress Notes
Summary:	The documentation reflected that ACS observed the SC during a home visit on 6/15/16; however, ACS did not make an assessment of the SC and did not interview the SC's father.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a corrective action plan 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:	Mandated reporters did not report potential abuse or maltreatment of a child
Summary:	ACS interviewed the now 5-year-old child and noted the child had a mark under her right eye. She said she was playing with the MGM's phone when the MGM became angry and threw the phone at her. She said she fell off the bed and got hurt.
Legal Reference:	SSL 413 and 415
Action:	ACS must submit a corrective action plan 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

The STM was known to the SCR and ACS as court ordered investigations (COI) were requested on 1/29/16 and 6/9/16. A Family Service Stage (FSS) was opened on 1//29/16. The BF filed for custody as he reported the MGM (STM of deceased SC) did not allow him to see his two children, the now 3-year-old and 5-year-old. The BF alleged the mother and children resided in one room with 5 people. During the investigation ACS engaged the 5-year-old child and noted the child had a mark under her right eye. She asked ACS not to tell the BF as it was a secret from him. She said she was playing with the MGM's phone, and the MGM got mad because she did not want to stop playing with the phone. The MGM threw the phone at her and she fell off the bed and got hurt. No report was made to the SCR and there was no documentation to reflect that the Specialist asked the MGM or mother to take the child to the Dr. for medical examination regarding this injury. ACS closed the FSS on 4/26/16.

On 6/9/16 ACS opened another FSS when the QCFC ordered ACS to conduct an updated COI. On 6/15/16 ACS staff visited the MGM's home and found the BM, MGM, now 3-year-old, now 5-year-old, and SC (now deceased) whom MGM introduced as her stepchild. There was no assessment of the SC. ACS documented that the custody case was adjourned until 10/24/16. ACS closed the FSS on 6/28/16.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**

01/29/2016	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	The BF filed for custody as he reported the MGM did not allow him to see his two children. The father alleged the mother and children resided in one room with 5 people. The BF reported he had his own home and he worked so he was able to provide a better life for his children. BF stated the oldest child should be in school but was not. ACS was ordered to investigate both homes and report on all the occupants of both homes. The BM and BF were required to have at least 3 random drug and alcohol screenings. ACS interviewed the MGM regarding the custody petition. MGM stated she did not think either parent should get custody of the children (the now 3-year-old and 5-year-old) because none of them were "fit to be good parents" of these children. She said she had been raising the children since they were born because the BF did not want them and the BM did not seem to be able to care for them as she was unstable. MGM stated that BF had been very violent toward the BM throughout their relationship and especially when she got pregnant. MGM stated she warned BM several time about him but she did not want to listen. The MGM stated the petition was started because she went to court to get custody of the children as neither BM nor BF wanted to give her money for the children. She stated when the BM filed for taxes, and received the returns she did not give BF any money; she spent everything on herself without thinking of the children. The MGM stated that this year, she (MGM) filed taxes with the children and the BF became angry. The MGM stated that if she was awarded custody, she would petition the court for supervised visitation for BM but would not allow the BF to see the children because he was violent. The MGM reported that the BF had never hit the children; however, the children were afraid of him. ACS documented that a report was submitted to the court; the custody case was adjourned until 6/7/16 and ACS closed the FSS stage on 4/26/16. On 6/9/16, ACS opened another Family Services Stage when the court ordered ACS to conduct an updated COI on the BM's, home and to report on suitability of the children to live with her. ACS was asked to report to the court by 6/22/16. On 6/15/16, ACS staff visited the MGM's home and found the BM, MGM, now 3-year-old, now 5-year-old and another child (9-years-old SC) whom MGM introduced as her step daughter, in the home. ACS documented that the apartment consisted of two bedrooms and a bathroom. ACS documented that the 5-year-old and the 3-year-old children shared a room with their BM and slept on a full size bed, while BM slept on another full size bed. The 9-year-old SC shared a room with MGM (STM) and the SF. ACS documented that the apartment was clean and well maintained, there were window guards on all the windows, and a functioning smoke and carbon monoxide detector. The BM explained she had moved in with the MGM after separating from her spouse through a mutual agreement. The BM stated she had requested custody of the children and would be providing finacially for them while the MGM would be the primary caretaker. Due to her work schedule she would "give her mother full permission" regarding the children's school, doctor's visit etc. She said she had already signed the required paper work giving the MGM "the right to legally care for the children." At the time of this visit the BM was 7 months pregnant. The BM indicated that she would ask the MGM to care for the newborn. There was no assessment regarding preparations for the	

	newborn given the cramped condition of the home. There was no assessment of the 9-year-old SC. The Specialist contacted the children's BF and he maintained his interest in caring for the children. On 6/28/16, ACS documented that the custody case was adjourned until 10/24/16 and closed the FSS stage.

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