Child Fatality Report

Report Identification Number: NY-18-047

Prepared by: New York City Regional Office

Issue Date: Nov 05, 2018

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: 7 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 05/18/2018
Initial Date OCFS Notified: 05/18/2018

Presenting Information

The 5/18/18 SCR report alleged that on 5/18/18, the SM brought the SC with her when she jumped out of a penthouse window. Both of them died upon impact.

Executive Summary

The 7-year-old male child (SC) died on 5/18/18. NYCRO had not yet received a copy of the ME's report at the time of the issuance of this fatality report.

At the time of the SC's death, the family had two open ACS investigations that were registered on 3/24/18 and 4/2/18, respectively. On 5/18/18, ACS was in the process of investigating these two reports when the SCR registered a report that included the allegations of DOA/Fatality and IG of the SC by the SM.

The SM was the primary caretaker for the SC and the BF had court ordered visitation. The SM and BF resided in separate homes and the SC visited with the BF every other weekend and once during the week.

ACS interviewed LE and learned that on 5/17/18 at about 5:56 PM, the SM and SC checked into a hotel. The hotel's room service was ordered at about 11:00 PM. A hotel employee had observed the SC at about 11:00 PM, and observed the SC was alert and healthy. The SM may have been depressed, but there were no descriptors provided. The SM jumped with the SC from the room's balcony on the 21st Floor of the hotel. A video tape was reviewed from the surrounding area. A possible timeline of the critical incident showed that at approximately 5:25 AM, the SM jumped with the SC. Their bodies were viewed on the Second-Floor roof of the adjacent building. At about 8:00 AM, the staff was notified by a guest who observed the bodies on top of the roof. The hotel contacted 911 at 8:05 AM. The documentation reflected the SM pushed the SC from the balcony and then she jumped. There were no surviving siblings or children in the household.

ACS offered the BF services and he declined. He sought services through a community based organization.

ACS documentation did not reflect that ACS interviewed or attempted to interview the hotel staff who had received the initial notification about the bodies being observed or other hotel staff.

On 7/17/18, ACS SUB the allegations of DOA/Fatality and IG of the of the SC by the SM. ACS based the determination on the preliminary oral report from the ME's office and LE reports. ACS explained that on 5/18/18, the SM and SC were found dead on the hotel compound. It was reported that the SM entered the hotel around 6:00 PM and ordered room service around 11:00 PM. The SM and SC were observed jumping from the room's balcony on the 21st Floor which was obtained from the video surveillance. According to LE, the ME's preliminary report ruled the SC's death a homicide. It was expressed that the balcony was intact and the railing on the balcony was very high.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
N/A

Was the decision to close the case appropriate? Yes
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:
There were no surviving siblings or other children in the home.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/18/2018 **Time of Death:** 08:23 AM

Time of fatal incident, if different than time of death: 05:25 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 08:05 AM
Did EMS 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

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	7 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	47 Year(s)
Other Household 1	Father	No Role	Male	47 Year(s)

LDSS Response

On 5/18/18, ACS interviewed LE and learned that the SF was notified of the incident. LE found the hotel room was orderly and nothing was observed to be out of the ordinary. There was a video of the SM exiting the elevator to go to her room around 6:00 PM. Every floor of the hotel had a balcony and the SM's room was on the 25th Floor. The SM and SC landed on the Second Floor at about 5:25 AM. LE verified there were no other individuals in the room with the exception of the SC and SM. There was no one observed leaving the elevator heading in the direction of the hotel room after the SM arrived in her room.

On 5/18/18, ACS visited the BF but was not allowed to enter his home as the BF said paternal relatives were visiting him. ACS staff interviewed the BF in the lobby of his residence. The staff expressed empathy and asked whether the BF needed assistance. The BF said he received assistance from LE. The BF informed ACS that he went to court on 5/16/18 and the SM was required to surrender the SC's passport. ACS did not inquire whether the BF referred to a Family Court or Supreme Court case. The BF was concerned the SM would take the SC and he would not have allowed his court ordered visitation with the SC. The last time he spoke with the SM was on 5/17/17. He said the SM told him she met someone with whom she had planned to be married. He said he told her he was happy for her and there was no indication something like this would happen. He informed ACS that he had not met the MGM and the SM was estranged from her family.

ACS reviewed Domestic Incident Reports (DIR) and criminal history records which revealed the family had DIR's concerning custodial disputes related to the SC and reports of DV in which the SM identified the BF as the aggressor. The documentation reflected the SM had 15 DIR's on file with LE. Eleven of the DIR's involved the SM and BF; the SM was listed as a victim in 10 of the reports that involved the BF. The BF was a victim in one of the DIR's that involved the SM. There were seven recent OPs issued on behalf of the SM. The most recent OP expired on 4/25/18.

On 5/24/18, LE stated that the NYPD and ATF conducted a joint firearm task force investigation. A concerned person provided an anonymous tip and the NYPD and ATF initiated contact with the BF and his attorney.

On 5/30/18, ACS confirmed with the Central Office of Home Schooling Office of School and Youth Development that the SC was registered for home schooling.

On 7/11/18, ACS spoke with the BF and inquired whether he would like assistance in obtaining bereavement services. He informed ACS that he planned to seek community based services.

On 7/17/18, LE informed ACS that the ME's preliminary report was received and the SC's death was ruled a Homicide. ACS learned that the ME would rule the SM's death a suicide, but LE was unaware whether the SM's report was completed. The cause of death was reported to be blunt impact to the head, neck, back, torso and extremities caused by descent from height. LE said the investigation was ongoing and the balcony was intact with a high railing. It was not suspected the SC was being beaten and it was determined that the injuries were sustained from the fall.

On 7/17/18, the ME's office said the autopsy reports were not finalized, but the death certificates were available. The cause of the SC's death was listed as homicide.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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: There is no OCFS Child Fatality Review Team in NYC.

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
047863 - Deceased Child, Male, 7 Yrs	047864 - Mother, Female, 47 Year(s)	DOA / Fatality	Substantiated
047863 - Deceased Child, Male, 7 Yrs	047864 - Mother, Female, 47 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☐	☐	☒	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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:
ACS was not allowed access to the SM's home or the hotel room due to an ongoing police investigation. ACS noted that the SM committed suicide. The SC was pronounced "dead on scene" and transported directly to the ME.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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	☐	☐	☐	☐	☐	☒	☐

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 surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The BF declined bereavement counseling.

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? N/A
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)	Allegation Outcome	Compliance Issue(s)
04/02/2018	Deceased Child, Male, 7 Years	Father, Male, 47 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The 4/2/18 SCR report alleged the BF had illegal weapons in his home and had repeatedly threatened to kill the SM and SC. Sometime in the past, the BF abused the SM and SC. Further details were unknown.

Report Determination: Unfounded | **Date of Determination:** 06/02/2018

Basis for Determination:
ACS unsubstantiated the allegation of IG of the SC by the BF on the basis of no credible evidence to substantiate the

allegation. ACS obtained information from LE who verified NYPD and the Bureau of Alcohol, Tobacco and Firearms (ATF) conducted an investigation as a joint firearm task force.

OCFS Review Results:
The SM said she and the BF had gun licenses. When she filed an OP, the BF's license was withdrawn, the BF surrendered one firearm, but kept an unregistered firearm. The SM did not know the location of the other three guns that she previously owned. She said she filed for a divorce after the BF threatened to kill her and the SC. On 4/18/18, a meeting occurred with the BF who said the reports were false and he did not have firearms in his possession. He was contacted by the ATF and the officials found he was in compliance. On 5/17/18, ACS contacted the SM by phone, but she did not answer. ACS learned about the SM and SC's deaths on 5/18/18.

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

Issue:
Pre-Determination/Supervisor Review

Summary:
The CPS Investigation Summary Investigation Conclusion Narrative was inadequate as it was incomplete as it did not provide pertinent information about the BF and his attorney's statement, and what the joint firearm task force found.

Legal Reference:
18 NYCRR 432.2(b)(3)(v)

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)	Allegation Outcome	Compliance Issue(s)
03/24/2018	Deceased Child, Male, 7 Years	Mother, Female, 47 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 7 Years	Father, Male, 47 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 3/24/18 SCR report alleged for the past seven months on an ongoing basis the BF fed the SC food that contained allergens. The BF was ordered by the courts to stop feeding the SC foods that contained allergens. The SC's health condition had deteriorated. The SC acquired bronchial spasms, swollen red bags under his eyes, and took medications as a result. The SM was aware of this and had failed to adequately intervene.

Report Determination: Unfounded **Date of Determination:** 05/23/2018

Basis for Determination:
ACS noted there was no credible evidence to substantiate the allegation of IG of the SC by the SM and BF. ACS interviewed the child's physician and medical specialist who both stated the SM and BF provided adequate care to the SC. The medical specialist expressed that the SC's symptoms were not due to the meals the SC consumed.

OCFS Review Results:
The SM said she contacted LE as the BF fed the SC food that resulted in allergic reaction. The SM reference the parents' divorce proceedings as a factor that contributed to the SC being ill. She said the SC was ill whenever he returned from a home visit with the BF. The BF said he filed for divorce and the SM threatened to have him arrested, which she had. The Dr. reported the SC's allergic reactions were due to the environment and not the food the SC consumed.

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

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
During the interview with the BF, he informed ACS that he and the SM received services from five counselors to address marriage issues. ACS documentation did not reflect whether he was asked for the contact information of those counselors nor the dates he received counseling services. The documentation did not reflect whether the SM was asked about contact with these counselors.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/21/2017	Deceased Child, Male, 7 Years	Father, Male, 47 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 7 Years	Father, Male, 47 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The 8/21/17 SCR report alleged that on an ongoing basis, the BF physically assaulted the SM in the presence of the SC. The BF shoved, pushed, choked, and restrained the SM. About two years prior to 8/21/17, the BF pushed the SC so hard the SC was in pain as a result. The BF hit the SC in the head and locked the SC out of the home for an unknown length of time. On 7/8/17, the BF slammed the door repeatedly on the SM's arm in the presence of the SC.

Report Determination: Unfounded | **Date of Determination:** 10/06/2017

Basis for Determination:
ACS noted there was no credible evidence that the BF did not provide a minimum degree of care for the SC. The BF provided food, clothing and shelter. The SC had medical insurance and had upcoming medical appointments.

OCFS Review Results:
The SM said that in July 2017 the BF pulled the SC 's arm when they were in upstate New York. The SC did not sustain any bruises. The SM contacted LE. The SM said she experienced DV with the BF, she obtained a stay away OP against the BF, and had an open Family Court case disputing visitation rights. The SC said the BF was mean to the SM. The SC was registered with the Office of Homeschool as per the NYC Department of Education. The BF was interviewed by Putnam County LDSS. The BF had a pistol permit and pistol, but due to the OP he turned it in to LE. He said he obtained counseling services where he was told he was a victim of DV.

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

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
ACS documentation did not reflect that ACS followed-up with the BF regarding the counselors who informed him that he was a victim of DV.

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:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
During the interview with Putnam County LDSS, the BF said the SM was hospitalized twice for a medical condition; however, ACS did not address this information with the SM to obtain additional information regarding the SM's health status.
Legal Reference:
432.1 (o)
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)	Allegation Outcome	Compliance Issue(s)
05/08/2016	Deceased Child, Male, 5 Years	Father, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The 5/8/16 SCR report alleged the BF had a history of harming the SC. The BF became frustrated with the SC, forcefully grabbed the SC by his ankles, hung him upside down by his ankles, and then hit him on the head three times. The SC had a history of a medical condition that was triggered by stress. The SC did not sustain any visible injuries; however, he had pain to his head and difficulty breathing due to the medical condition being triggered.

Report Determination: Unfounded | **Date of Determination:** 06/17/2016

Basis for Determination:
ACS unsubstantiated the allegation of IG of the SC by the BF on the basis that there was no credible evidence to support the allegation. ACS explained that the staff observed there was one small red mark on the SC's left arm. The SC had not made any complaints in regard to being physically harmed.

OCFS Review Results:
On 5/9/16, the SM said the SC told her the BF hung him upside down by the legs and walked around with him, hit him on the head three times then threw him on the sofa. The SC used a toy to demonstrate how the BF held him by his ankles upside down. ACS interviewed the BF, who was accompanied by his attorney, at the LDSS office. ACS interviewed the family's counseling service provider who had no concerns of abuse/maltreatment of the SC. On 6/7/16, a meeting occurred and the parents agreed to continue to receive counseling services with their service provider. The BF said the SM purchased a firearm. ACS did not discuss the SC's access to the firearm.

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

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS documentation did not reflect that ACS addressed whether the SC had access to the firearm, although possession of a firearm was discussed with the BF. The BF said the SM purchased a firearm.
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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/23/2015	Deceased Child, Male, 5 Years	Father, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The 11/23/15 SCR report alleged the BF had a history of verbal and physical violence towards the SM and SC. When the SC was an infant, the BF assaulted the SM while she was holding him. The SC was not injured. On 11/11/15, the BF became angry with the SC at bedtime because the SC pushed him. The BF pushed the SC with force causing him to fall back and cry out in fear. The SM intervened. The BF then became verbally abusive towards the SM as a result. The SM and SC were fearful of the BF. The situation was on-going and accelerating.

Report Determination: Unfounded **Date of Determination:** 01/15/2016

Basis for Determination:
ACS unsubstantiated the allegation of IG of the SC by the BF on the basis that the family denied they were engaged in physical altercations. The SM reported she and the BF had verbal arguments in the past. She said she did not sustain any injury and she denied the SC was injured. The SM said she and the BF were seeking counseling services with a private therapist. ACS explained that the SC's basic needs were being adequately met.

OCFS Review Results:
ACS interviewed the SM who denied there was any violence in the home. She said she contacted service providers to obtain counseling. The SM denied verbal abuse and said her and the BF had arguments. She said the MGF died on 7/26/15 and following his death she struggled emotionally. The SM denied DV, substance abuse and clinical health issues. The SC said the BF pushed him a very long time ago. The SC did not describe how the BF pushed him. On 11/25/15, the BF informed ACS he was aware of the ACS investigation and agreed to meet with ACS on 12/1/15. The documentation did not reflect that ACS interviewed the BF who was the subject of the 11/23/15 report.

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

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
ACS documentation did not reflect that ACS interviewed the BF who was the subject of the 11/23/15 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.

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

The SM did not have CPS History more than years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

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

Have any Orders of Protection been issued? Yes	
From: 03/28/2018	**To:** 04/25/2018
Explain: ACS documentation reflected there were seven recent OP's issued for the SM regarding the BF. The most recent OP expired on 4/25/18.	
From: 07/13/2017	**To:** 08/30/2017
Explain: The SM obtained an OP against the BF for herself and the SC. The documentation reflected that the OP was filed on 7/13/17. The OP was modified on 8/11/17 permitting the BF to have visitation with the SC on Wednesday evenings and every other Saturday.	

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