Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-037

Prepared by: New York City Regional Office

Issue Date: Oct 23, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 12 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 04/27/2020
Initial Date OCFS Notified: 04/27/2020

Presenting Information

The SCR registered two reports alleging the mother and the PS smoked cigarettes and marijuana in the presence of the children, the 12 yo SC who suffered from a respiratory condition and her 2 siblings. The report stated that the mother and the PS were aware of the SC's condition, but took no precaution. As of result, on 4/27/20, the SC woke up with difficulty breathing, and the mother administered her treatment and called 911. The SC was transported to the Brookdale Hospital where she was pronounced dead at approximately 11:00 A.M. The reports also stated that drugs in the home were left accessible to the children.

Executive Summary

At the time of her death, the SC was 12 yo. According to the OCME, the SC's body was referred for cremation approval. However, the medical staff who attended to the SC indicated the cause of death was due to respiratory distress caused by her medical condition and the manner of death was natural.

The SC resided with her mother, siblings and the PS who was the father of the 5 yo sibling.

The family had an active family court case involving the father of the SC and the 8 yo sibling for custody and domestic violence (DV) issues. Therefore, the father had supervised visits with his children.

On 4/27/20, the SCR registered a report pertaining to the SC's death. The allegations of the report were DOA/FATL of the SC; and PD/AM and IG of all the children by the mother and the PS.

According to ACS' investigation, on 4/27/20, the SC woke up having respiratory problems. The mother and the PS used the SC's nebulizer with her prescribed medication and took her out on the balcony to get air. The mother and the MU called 911. EMS transported the SC to Brookdale Hospital where she was pronounced dead. The PS stayed in the home to care for the siblings while the SC was transported to the hospital.

ACS initiated the investigation timely and assessed the home within the required time frame. ACS found the home was appropriate with adequate provisions for the children; and they were deemed safe. Throughout the investigation, ACS maintained contact with the family via home visits and video chat. ACS did not observe any drug paraphernalia or indication of drug use by the mother or the PS. ACS conducted body checks at all visits and there were no suspicious marks or bruises on the siblings. ACS appeared to have been successful with engaging the family and had several safe sleep discussions with the mother.

ACS interviewed medical staff and there were no signs of trauma or abuse involving the SC's death. The medical staff determined the SC died of natural causes due to her medical condition. ACS followed up with the SC's medical specialists and found the mother was consistent with following up with the SC's medical appointments and treatments.

The NYPD found no foul play involving the mother or the PS in connection to the SC's death. Therefore, no criminal charges were pursued.

Throughout the investigation, ACS gathered relevant information of the circumstances surrounding the SC's death. In practice, ACS was thorough with their safety assessments and determined the siblings were safe in the care of the mother

and the PS. However, the information was not utilized to properly complete the safety instruments. The safety instruments focused on the mother's DV with the BF and/or comments about the SC. Based on the case documentation, throughout the investigation there were no safety factors pertaining to the siblings. OCFS provided ongoing technical assistance, primarily on the completion of the safety assessments but there were no adequate modifications.

On 8/24/20, ACS unsubstantiated the allegation of the DOA/FATL based on the information provided by the medical staff who determined the SC died from natural causes and the mother and the PS responded appropriately when they found the SC unresponsive.

The allegation of PD/AM and IG were unsubstantiated as ACS conducted unannounced visits to the home and there were no signs of drug or alcohol use in the home. Also, the children's needs were all adequately met.

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?** Unknown
  - **Safety assessment due at the time of determination?** Unable to Determine
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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 appropriate?** N/A

Explain:
Determination pending.

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

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

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

Explain:
There were supervisory notes; however, they were not focused on the family's circumstances or the allegations of the SCR report. Although assessments were approved by supervisory/managerial staff, they were not completed properly.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	24 Hour safety assessment was not completed properly, safety decision and safety plan were not relevant to the family circumstances or the reported allegations.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 7-Day safety assessment was not completed properly, safety decision and safety plan were not relevant to the family circumstances or the reported allegations.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The documentation was convoluted and focused on the mother's DV history with the father and the circumstances of the SC's death instead of an assessment of the safety of the SS.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/27/2020 **Time of Death:** 11:00 AM (Approximate)

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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? No - Not needed given developmental age or circumstances

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	12 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	47 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	47 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	47 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Month(s)
Other Household 1	Father	No Role	Male	38 Year(s)

LDSS Response

Upon receipt of the reports, ACS initiated the investigation by contacting medical staff and the NYPD.

The medical staff at BH, there were no signs of trauma involving the SC's death. The doctor determined the SC died of natural causes due to her medical condition. The doctor indicated that EMS performed CPR prior to the SC's arrival at the hospital, but she was DOA. The mother seemed concerned about the SC and reported when the SC woke up with difficulty breathing, she tried to treat her at home. The mother said she called 911 when the SC's condition did not improve. The SC was tested for COVID-19 and the result was negative. ACS followed up with the SC's medical specialists and found the mother was consistent with following up with the SC's medical appointments and treatments. The parents denied smoking in the presence of the SC.

The NYPD found no criminality involving the SC's death.

The mother and PS provided a timeline leading to the 911 call. According to the mother and PS, on 4/26/20, the SC was home and had no signs of distress. She played table games with the 8 yo and the MU throughout the day. The children went to sleep at about 9:45PM. The mother said the SC was up at 1:00 AM to get some water and went back to sleep. The mother and the PS were awakened by the 5 mo at about 4:00AM for a feeding. The PS went to prepare a bottle for the 5 mo and noticed the children's door was closed so he figured everything was fine. The mother returned to sleep at 5:00AM, and the PS a 5:30AM. At 6:00AM, the PS woke up to use the bathroom and heard the SC wheezing, so he went to check the SC and noticed the windows in the children's room were open. He said he closed the windows and saw the SC was awake. The SC told the PS she was okay, and he reminded her to take her medication once she got up. Sometime between 6:15AM and 6:30 AM, the SC was sitting on the floor of her room administering her treatment. The PS stated that he went to wake up the mother to alert her that she needed to check the SC. The mother went to the room and found the SC standing and leaning on the bed with her "head in her arm". The mother said the SC kept repeating that her chest was tight and about 6:30AM. she called 911. The mother moved the SC to the living room, placed her on the nebulizer, and then took the SC to the balcony to get fresh air. The mother said the SC appeared to be "slumped" and began saying that,

"everything was turning black." The SC then collapsed onto the PS and he carried her back to the living room and placed her on the nebulizer. However, the SC was unresponsive, and the mother called 911 again at 6:49AM. The PS gave the SC chest compressions until EMS arrived sometime between 7:10AM and 7:15AM. The mother and the PS stated that when EMS arrived, the SC had a heartbeat and was transported to BH where she was pronounced dead. The mother said the children had not left the home since the quarantine for COVID-19. The mother and the PS reported that the reason why the window was left open was because their apartment was located above a laundromat and the room was always very hot. The mother and the PS were asked about the PD/AM allegation, however, the PS admitted he smoked cigarettes outside of the home. ACS assessed the siblings and the condition of the home, and deemed them to be safe in the care of the mother and the PS.

The 8 yo reported he was asleep and when he woke up, he heard everyone "panicking" and yelling. The 8 yo said he did not see the SC but later learned his mother had taken her to the hospital where she died. The MU corroborated the family's activities for 4/26/20 and the events leading to the 911; he had no concerns about the mother's or the PS' ability to care for the SC.

ACS contacted medical providers and the children's school and no one reported any concerns about the mother or the care being provided to the children.

ACS unfounded the reports on 8/24/20

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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: There was no documentation of an MDT response; however, 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 the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054625 - Deceased Child, Female, 12 Year(s)	054840 - Mother's Partner, Male, 47 Year(s)	DOA / Fatality	Unsubstantiated
054625 - Deceased Child, Female, 12 Year(s)	054840 - Mother's Partner, Male, 47 Year(s)	Inadequate Guardianship	Unsubstantiated
054625 - Deceased Child, Female, 12 Year(s)	054840 - Mother's Partner, Male, 47 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
054625 - Deceased Child, Female, 12 Year(s)	054626 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated

054625 - Deceased Child, Female, 12 Year(s)	054626 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
054625 - Deceased Child, Female, 12 Year(s)	054626 - Mother, Female, 35 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
054833 - Sibling, Male, 8 Year(s)	054840 - Mother's Partner, Male, 47 Year(s)	Inadequate Guardianship	Unsubstantiated
054833 - Sibling, Male, 8 Year(s)	054840 - Mother's Partner, Male, 47 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
054833 - Sibling, Male, 8 Year(s)	054626 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
054833 - Sibling, Male, 8 Year(s)	054626 - Mother, Female, 35 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
054834 - Sibling, Female, 5 Month(s)	054840 - Mother's Partner, Male, 47 Year(s)	Inadequate Guardianship	Unsubstantiated
054834 - Sibling, Female, 5 Month(s)	054840 - Mother's Partner, Male, 47 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
054834 - Sibling, Female, 5 Month(s)	054626 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
054834 - Sibling, Female, 5 Month(s)	054626 - Mother, Female, 35 Year(s)	Parents Drug / Alcohol Misuse	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

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 assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☐	☐	☐	☒
At 30 days?	☐	☒	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Explain:
The 24 Hour safety assessment was not completed properly, as the safety decision and safety plan were not relevant to the family circumstances or the reported allegations. For the 7-day safety assessment, the documentation was convoluted. The documentation was focused on the mother's DV history with the father and the circumstances of the SC's death and not on an assessment of safety of the surviving siblings.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
N/A

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐

Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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 immediate needs for the siblings in response to the fatality. ACS provided suggestions for bereavement and the mother initiated some contacts to secure this service.

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

There were no immediate needs in response to the fatality. However, ACS provided resources for the parents and the PS for bereavement.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/25/2019	Deceased Child, Female, 11 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 5 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 11 Years	Mother's Partner, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
On 1/22/19 at about 5:50pm the mother and the parent substitute physically assaulted the father while the children were present. During the assault, the parent substitute grabbed the father by the neck and the mother and parent substitute proceeded to cut the father on the legs with knives and box cutters. It was unknown if the mother or parent substitute were intoxicated at the time of the assault. It was unknown if the children sustained any injuries as a result. It was unknown if the mother or parent substitute have a history of this behavior.

Report Determination: Unfounded | **Date of Determination:** 03/21/2019

Basis for Determination:
ACS unsubstantiated the allegation of IG and Lack of Supervision against the mother and parent substitute regarding the children. It was reported that the mother held the children's father while her paramour proceeded to cut him with a box cutter. The children denied that this occurred, and the father even stated that the children were not present when he was being attacked. Based on the information gathered during the case, no credible evidence was found to indicate the case.

OCFS Review Results:
ACS investigated the allegations of the report and made contact with law enforcement. The report was initiated in a timely manner and the safety assessments were appropriate.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/29/2018	Deceased Child, Female, 10 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 10 Years	Mother, Female, 35 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 35 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Female, 10 Years	Mother's Partner, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 10 Years	Mother's Partner, Male, 37 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 6 Years	Mother's Partner, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother's Partner, Male, 37 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
The SCR registered a report stating that the PS assaulted the children's father in the presence of the 6 yo. The report stated the PS pulled out a belt and began to hit the father with it and as a result the father sustained bruising to his back. The 6 yo did not sustain any injuries.

The report also stated the mother had a history of leaving the children alone unsupervised. It was alleged that two days prior to the report, the mother left the 6 yo and 10 yo SC home alone for 6 hours without adult supervision, and returned at 11:00 P.M.

Report Determination: Unfounded | **Date of Determination:** 05/25/2018

Basis for Determination:
ACS unsubstantiated the allegation of LS and IG based on the interviews with the family and the babysitter. Their accounts were consistent noting that whenever the mother and the PS were out, the BS provided supervision for the children.

OCFS Review Results:
The investigation was completed within the parameters of SS Laws and NY Code of Rules and Regulations.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/09/2017	Deceased Child, Female, 10 Years	Mother's Partner, Male, 44 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Deceased Child, Female, 10 Years	Mother's Partner, Male, 44 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 44 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 44 Years	Inadequate Guardianship	Unsubstantiated	

Deceased Child, Female, 10 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Female, 10 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 5 Years	Mother, Female, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
It was reported that the parent substitute was abusing marijuana in the presence of the child who has asthma. The smoke was exacerbating the child's asthma. The mother and parent substitute were leaving the marijuana out and accessible to the children. The mother was allowing the child to watch sexual videos on her cell phone.

Report Determination: Unfounded | **Date of Determination:** 12/26/2017

Basis for Determination:
ACS unsubstantiated the allegations against the mother as she was meeting all basic needs of the children and protect them. The mother denied the allegations and so did the children. The children stated that they had never observed mother or anyone using any drugs or substances. The home was assessed to be clean and safe. The children both attend school on a regular basis.

The allegation of INGD against the PS was unsubstantiated as he did not live in the home and only assisted mother as needed. The PS denied any drug use and denied ever seeing mother use any drugs or other substances.

OCFS Review Results:
The investigation was initiated in a timely manner. ACS made the appropriate collateral contacts and explored information obtained.

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

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

The parents of the SC and the now 8 yo were known in three reports dated 9/24/14, 1/17/15 and 6/25/15. The allegations of these reports were IFCS, and IG.

The family became known to ACS with the allegation of IG of the children by the mother. The report stated the mother allegedly failed enforce OOP against the father. Allegations of IG and Inadequate Food/Clothing/Shelter were filed against the father in that he allegedly perpetrated acts of Domestic Violence in front of the children as well as failed to ensure proper food/clothing/shelter for the children. The case was filed in Brooklyn Family Court in 01/2015 against the mother and father. The children were released to the mother with ACS supervision.

On 3/17/16, the case was heard in court for continued Fact Finding. During the court Proceedings, ACS dismissed the case without prejudice against mother and father. At this time there are no further court dates and the OOP is no longer in effect.

There was no further need for supervision as case was dismissed in Brooklyn Family Court. The case was closed.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

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