Child Fatality Report

Report Identification Number: NY-22-082

Prepared by: New York City Regional Office

Issue Date: Mar 24, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 6 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 10/04/2022
Initial Date OCFS Notified: 10/04/2022

Presenting Information

An SCR report alleged the 6-year-old subject child resided with his mother and had visitation with his father. On 10/3/22, the child was visiting overnight with his father. On 10/4/22, at 2:00 AM, the father woke up and noticed the child was vomiting and defecating on himself. The father cleaned up the child, and the child went back to sleep. At 8:53 AM, the father called 911 because he noticed the child was unresponsive. At approximately 9:00 AM, emergency medical services arrived at the father's home and performed CPR. The child was then transported via ambulance to the hospital. At approximately 9:53 AM, the child was pronounced deceased. The child was otherwise healthy and the father had no explanation for the child's death. The role of the mother was unknown.

Executive Summary

On 10/4/22, an SCR report was received regarding the death of the 6-year-old male subject child that occurred on that date. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the father of the subject child. The Administration for Children's Services (ACS) received the report and investigated the child's death. At the time of the child's death, he resided with his mother and 3-month-old sibling. The father of the 3-month-old sibling frequently visited the mother's home and assisted with caring for the children. The fatal incident occurred at the home of the subject child's father while the child was there on visitation. The subject child's father had custody of his 10-year-old nephew (the subject child's cousin), and the cousin was present for the incident. The cousin's mother was deceased and the location of the cousin's father was unknown. The subject child's father had a 6-year-old daughter that resided with her mother and did not have visitation with the father. The surviving children were assessed to be safe with their caretakers.

The investigation revealed that on 10/4/22, around 8:50 AM, the subject child's father woke up and found the subject child unresponsive in the father's bed. The father called 911 and performed CPR until EMS arrived and took over. EMS performed life-saving measures and transported the child to the hospital via ambulance. Efforts to resuscitate the child were unsuccessful and he was pronounced deceased at 9:53 AM. An autopsy was performed, and the cause of death was Acute Lymphocytic Leukemia, and the manner of death was natural. Law enforcement investigated the child's death, and they closed their case with no charges filed.

ACS found the child's death was not due to abuse or maltreatment and they unsubstantiated the allegations. A preventive services case was opened to provide the family with family counseling, parenting skills classes, and bereavement counseling. The 3-month-old sibling was referred for early intervention services.

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

Explain:
The case was appropriately unfounded and opened for preventive services.

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:
Casework activity was commensurate with case circumstances.

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: 10/04/2022 **Time of Death:** 09:53 AM

Time of fatal incident, if different than time of death: 08:50 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:53 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

☒ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

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	Male	6 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Month(s)
Other Household 1	Father	Alleged Perpetrator	Male	29 Year(s)
Other Household 1	Other Child - Cousin	No Role	Male	10 Year(s)
Other Household 2	Other Adult - 3-month-old Sibling's Father	No Role	Male	34 Year(s)

LDSS Response

ACS investigated the child's death by reviewing SCR history and referring the child's death to the district attorney's office. ACS conducted home visits at the father's and mother's homes, and interviewed all household members. The homes were assessed to be safe and safe sleep education was provided to the mother and 3-month-old sibling's father. ACS spoke to the source of the report, law enforcement, the medical examiner, hospital staff, the children's pediatricians, and school staff. Notice of the report was provided to all parents, and safety assessments, the RAP, and fatality reports were completed timely and accurately.

During interviews with the parents it was learned that the subject child was in good health other than high blood pressure on occasion. He was up to date with well-child visits and he was taking prescribed medication as needed for a chronic lung condition. The child had recently been seen at the hospital for a mental health evaluation and he was scheduled to begin outpatient counseling.

The father said the child came to his home around 3:00 PM on Friday, 9/30/22, and the child appeared to be in good health at that time. He said the child slept in his bed with him when the child visited. Around 2:00 AM on Sunday 10/2/22, the child began complaining of stomach pain and he vomited and urinated on himself. The father cleaned the child up and they went back to bed. The child continued to vomit on and off throughout the day on Sunday. Throughout the day on Monday 10/3/22, the child continued to complain of a stomachache and he vomited and had diarrhea on and off. The father said the mother came over and made the child soup and they discussed taking the child for medical care, but the child did not want to go. At 2:00 AM on Tuesday 10/4/22, the child vomited and then went back to bed. At 8:50 AM, the cousin knocked on the father's bedroom door. When the father rolled over, he saw that the child was unresponsive, and he called 911. The cousin reported that the child was fine when he first came to the father's home and then he started vomiting. He did not provide any other details about the fatal incident.

The mother stated that the father called her on 10/2/22 and told her the child was sick. She confirmed that she went to the father's home on 10/3/22 and the child was vomiting when he tried to eat food, but he was running around and alert. She wanted to take the child to the doctor, but the child refused so she and the father decided to give it another day and see how the child was. The father called her at 8:55 AM on 10/4/22 and told her the child was unresponsive and he had called 911. She immediately went to the hospital, where she was informed the child did not have a heartbeat and she agreed to stop medical intervention.

Hospital staff reported the child was in cardiac arrest when EMS arrived at the home. EMS tried to intubate the child, but

his jaw was stiff due to rigor mortis. CPR continued at the hospital, but the child could not be resuscitated, and he was pronounced deceased at 9:53 AM. There were no signs of external trauma. The child had a diagnosed genetic condition that affected his hemoglobin in his blood, he had a chronic lung condition which he was taking prescribed medication for, and he was overweight. It was unknown if the diagnosed conditions contributed to the child's death. Hospital staff further reported that the father told them the child had been vomiting and had diarrhea for 2 days prior to his death.

The subject child's pediatrician's office reported the child's last well-child appointment was on 8/26/22. The child was overweight but overall healthy and he had not been previously diagnosed with Leukemia. The child was referred to specialists for weight management, ophthalmology, and endocrinology; however, it was unknown if the parents followed through with the referrals. The sibling and cousin's pediatricians had no concerns for their care.

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)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062932 - Deceased Child, Male, 6 Yrs	062936 - Father, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
062932 - Deceased Child, Male, 6 Yrs	062936 - Father, Male, 29 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

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?	☐	☐	☒	☐

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: Risk was adequately assessed and the case was opened for preventive services.				

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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? Yes

Explain:

The cousin and 3-month-old children received preventive services, including an early intervention referral and bereavement services following the child's death.

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

Explain:

The family received preventive services following the child's death, including bereavement services, family counseling and parenting skills classes. The family was offered funeral assistance and they declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	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?	Yes

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)
04/02/2022	Other Child - Cousin , Male, 10 Years	Father, Male, 29 Years	Choking / Twisting / Shaking	Unsubstantiated	No
	Other Child - Cousin , Male, 10 Years	Father, Male, 29 Years	Educational Neglect	Unsubstantiated	
	Other Child - Cousin , Male, 10 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

An SCR report alleged that on 3/31/22, the father became upset and choked the cousin when he asked for his cell phone back. The father was violent with the cousin in the past. The cousin was regularly absent from school and he was failing as a result. The father was made aware but he did not ensure the cousin attended school. The alleged unrelated home member was buying and selling drugs out of the home when the cousin was present. The father and unrelated home member were abusing marijuana in the presence of the cousin, which had an unknown effect on the cousin.

Report Determination: Unfounded | **Date of Determination:** 06/01/2022

Basis for Determination:

ACS found a lack of evidence that the father choked the cousin. The cousin was observed to have no marks or bruises and he reported the father used an open hand to tap him on the shoulder. The father denied using physical discipline on the cousin or using marijuana while caring for the cousin. The cousin said the father smoked marijuana in the home but denied he acted differently afterward. The cousin was attending school and an after-school program regularly. ACS assisted the father with providing a letter to school staff to request an IEP evaluation. The father denied knowing who the alleged unrelated home member was and stated no one besides himself and the cousin resided in the home.

OCFS Review Results:

ACS conducted home and school visits and interviewed the father and cousin. Safety Assessments and the RAP were completed timely and accurately. The home was assessed to be safe with no drugs or paraphernalia observed. Family members and school staff were spoken to and school and medical records were reviewed. ACS completed substance abuse and medical consultations. The father declined a drug test and ACS provided him with information on substance

abuse treatment and mental health services.

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)
04/07/2021	Other Child - Cousin , Male, 9 Years	Father, Male, 28 Years	Educational Neglect	Substantiated	No
	Other Child - Cousin , Male, 9 Years	Father, Male, 28 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Other Child - Cousin , Male, 9 Years	Mother, Female, 28 Years	Educational Neglect	Unsubstantiated	

Report Summary:
An SCR report alleged the cousin was absent 83 days out of 114 days in session during the 2020-2021 school year. As a result, the cousin was failing all his classes. The father and mother of the subject child were aware and failed to adequately address the situation.

Report Determination: Indicated **Date of Determination:** 06/11/2021

Basis for Determination:
ACS found evidence the father, who had legal custody of the cousin, had the cousin staying with different family members for weeks at a time and he did not secure stable housing for the cousin. The father did not make sure the cousin was logging in for remote learning and completing school work daily. The father failed to attend a school conference to plan for the cousin's education. The cousin had an IEP and was failing his classes due to excessive absences. At that time, the father resided with the subject child and mother, so the mother was an alleged subject on the report; however, the mother was determined not to be a person legally responsible for the cousin.

OCFS Review Results:
ACS conducted a home visit and interviewed the father, cousin, and subject child. Safety Assessments and the RAP were completed timely and accurately. Attempts to follow up with the father were unsuccessful. A visit was conducted at the cousin's family member's home and it was learned the cousin had been staying with the family member for several weeks and he did not have the school electronics needed to log into classes. The father moved into an apartment and the cousin returned to the father's care. School staff and medical providers were spoken to. A preventive services case was opened to continue to monitor the cousin's educational and housing needs were being met by the father.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/07/2021	Other Child - Cousin , Male, 8 Years	Father, Male, 27 Years	Educational Neglect	Far-Closed	No

Report Summary:
An SCR report was tracked FAR with concerns the cousin missed 47 days of school during the 2020-2021 school year thus far despite having the necessary equipment to engage in online learning. The last time he was in school was 11/17/20. As a result, he was failing his classes. The father was aware but failed to adequately address the situation.

OCFS Review Results:
ACS conducted home visits and spoke to the father, cousin, and paternal aunt that was assisting with the cousin's care. The cousin was assessed to be safe in the care of the father and paternal aunt. The cousin's attendance concerns were addressed with the family. The family contacted school staff to register the cousin for full remote learning and to have the cousin's electronic device fixed. The family agreed to ensure the cousin logged in for classes and completed schoolwork

daily. The 7-Day Safety Assessment was completed timely and accurately and the FLAG was completed with the family. School staff were spoken to and no service needs were identified.

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)
02/21/2020	Other Child - Cousin , Male, 8 Years	Father, Male, 27 Years	Excessive Corporal Punishment	Unsubstantiated	No
	Other Child - Cousin , Male, 8 Years	Father, Male, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged in December 2016, the father hit the cousin on his head with enough force that the cousin fell to the ground and began crying. The cousin did not sustain any injuries during the altercation.

Report Determination: Unfounded | **Date of Determination:** 04/17/2020

Basis for Determination:
The alleged incident in which the father was physically aggressive toward the cousin occurred in December 2016 and was previously investigated and substantiated for Inadequate Guardianship. On 2/4/20, the father was arrested on a warrant for not completing the previous services that were mandated by criminal court, and an order of protection was issued against him regarding the cousin. The cousin stayed with the paternal aunt while the father completed the services. The father and cousin denied any incidents of physical discipline occurred since 2016 and the cousin denied he ever had marks or bruises from the father disciplining him. A Preventive Services case remained open.

OCFS Review Results:
ACS conducted home visits and interviewed the father, cousin and paternal aunt. Safety Assessments and the RAP were completed timely and accurately. Relevant collateral contacts were made with the cousin's pediatrician, school staff, law enforcement, preventive services agency, and the cousin's mental health provider. Collateral contacts had no concerns for the father's care of the cousin. ACS verified the family was engaged in mental health services and the father was enrolled in court mandated parenting classes.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/18/2019	Other Child - Cousin , Male, 7 Years	Father, Male, 26 Years	Inadequate Guardianship	Far-Closed	No
	Other Child - Cousin , Male, 7 Years	Father, Male, 26 Years	Lack of Medical Care	Far-Closed	

Report Summary:
An SCR report was tracked FAR with concerns the cousin had a history of throwing chairs, hitting other children, and throwing objects at adults. The cousin was in need of a medical evaluation and mental health services to address his out of control behavior. The father was aware of the cousin's needs, yet he failed to follow through with obtaining these services for the cousin and the cousin continued to behave in this manner.

OCFS Review Results:
ACS conducted home visits, spoke to the father and cousin, and spoke to school staff. The 7-Day Safety Assessment was completed timely and accurately. Notice of FAR and FAR closing letters were provided to the father timely and the FLAG was completed with the family. ACS confirmed the father and cousin were engaged with preventive services. The cousin was receiving in-home counseling and was referred to a community agency for additional mental health services.

The FAR case closed and a new SCR report was made when the father was arrested on a warrant for not completing services that were previously mandated in criminal court.
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

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

7/29/19 Unsub against the father for the allegations of Inadequate Food/Clothing/Shelter, Inadequate Guardianship and Parent's Drug/Alcohol Misuse regarding the cousin. The family was referred for preventive services.

4/27/18 Sub against the father for the allegation of Educational Neglect regarding the cousin. The family continued to engage in preventive services.

12/21/16 Sub against the father for the allegations of Inadequate Guardianship regarding his now 6-year-old daughter and the cousin. ACS filed an Article 10 Neglect Petition against the father for an incident where the father was physically aggressive towards the cousin in the presence of the now 6-year-old. The case opened for mandated preventive services.

Preventive Services History

6/11/21-6/23/21 A Preventive Services case opened to monitor the cousin's educational and housing needs were being met.

A Preventive Services case opened on 9/17/19 to assist the father in meeting the cousin's educational and behavioral needs. The cousin received in-home individual and family counseling services through a preventive agency as well as mental health counseling at a community agency. An IEP evaluation was completed and the cousin received services at school. The father was arrested on 2/4/20 due to a warrant for not completing parenting classes and anger management, which were previously mandated in criminal court. The father engaged in anger management, parenting classes and DV classes. The case closed on 10/14/20 at the father's request with service plan goals achieved.

A Preventive Services case opened on 12/22/16 following an indicated CPS investigation for an incident where the father was physically aggressive towards the cousin in the presence of his now 6-year-old daughter, resulting in criminal charges. An Article 10 Neglect Petition was filed and court-ordered supervision was granted. The father's now 6-year-old daughter was released to the custody of her mother, and the cousin remained in the father's custody. The father completed family court orders and the case closed on 7/30/18 with service plan goals achieved.

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