Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-049

Prepared by: New York State Office of Children & Family Services

Issue Date: Nov 03, 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
Jurisdiction: New York
Date of Death: 05/18/2023
Age: 13 year(s)
Gender: Male
Initial Date OCFS Notified: 05/18/2023

Presenting Information

The Administration for Children's Services (ACS) completed an OCFS-7065 Agency Reporting Form on 5/19/23, after learning of the 13-year-old subject child's death. There was an open services case at the time of the death.

Executive Summary

On 5/18/23, ACS was informed of the death of the 13-year-old male subject child. ACS had an open services case, which began on 1/27/23, due to concerns regarding the 3-year-old sibling's medical and developmental needs being met, the subject child's high-risk behavior within the community and at school, and the recent history of domestic violence in the presence of the children. Prior to the subject child's death, he resided with his mother and sibling. The subject child's father was incarcerated, and the sibling's father had an active order of protection in favor of the sibling.

ACS completed casework and collateral contacts and learned that on 5/12/23, the subject child left a family gathering with a friend. It was reported the subject child and his friend fell into a local river around 9:00PM on the evening of 5/12/23. The circumstances leading up to the subject child falling into the river were unknown. Multiple searches were conducted by law enforcement, the family, and the community. The subject child's body was recovered from the river on 5/18/23 and he was pronounced deceased.

An autopsy was performed, and the cause of death was drowning, and the manner was accident. The autopsy noted the subject child sustained minor blunt force injuries to the head, including abrasions and superficial lacerations. ACS did attempt contact with law enforcement regarding the open criminal investigation surrounding the subject child's death; however, the record did not reflect that ACS discussed the circumstances of the subject child's death with law enforcement. The status of the criminal investigation was unknown.

Bereavement services and burial assistance were offered to the mother. Following the subject child's death, the sibling's paternal grandmother was granted temporary custody of the sibling with the mother having unsupervised visitation three times a week for four hours. The paternal grandmother refused services on behalf of the SS and the services case was closed on 9/8/23.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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

Explain:
This was a non-SCR reported fatality, and therefore, no determination was made.

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 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: 05/18/2023 **Time of Death:** Unknown

Date of fatal incident, if different than date of death:	05/12/2023
Time of fatal incident, if different than time of death:	Unknown

County where fatality incident occurred:	New York
Was 911 or local emergency number called?	Unknown
Did EMS respond to the scene?	No
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: 2
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	13 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

ACS began gathering information regarding the fatal incident at the time they learned of the subject child's disappearance on 5/16/23.

The BM was interviewed regarding the events preceding the SC's death. The BM reported the SC was at a cookout on 5/12/23 with her after a maternal aunt's funeral. The BM told the SC he would be going down south with relatives, and the SC stated he was not going. The SC walked away from the family gathering around 6:00-6:30PM on 5/12/23. The BM reported some family and friends reported seeing the SC around 1:30AM and 4:30PM on 5/13/23; however, it was reported the SC and his friend were witnessed falling into the river around 9:00PM on 5/12/23. Multiple searches occurred and law enforcement recovered the SC's body from the river on 5/18/23. The BM reported that she obtained information that a third child was with the SC and his friend. An altercation occurred and the other child reportedly pushed the SC into the river, and his friend attempted to help him. The record did not reflect this information was discussed or confirmed by law enforcement.

The record did not reflect that ACS explored with the BM what occurred after the SC walked away from the family gathering and what steps she took in order to try to locate the SC to determine if there were concerns for a lack of supervision.

Upon learning of the SC's death on 5/18/23, ACS offered the BM services. The BM accepted burial assistance, but it was unknown if she was engaged in grief counseling. The SS was in need of an appointment with an audiologist and an evaluation regarding his speech delay; however, the SS's PGM refused services and assistance from ACS after obtaining custody of the SS. The SS was assessed to be safe in the PGM's care. The SS's father had an active OP until 9/3/23, but the record reflected the SS's father having contact with the SS in 8/2023.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: ACS does not have an OCFS-approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
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	☒	☐	☐	☐

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?

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: 03/01/2023	**To:** 09/03/2023
Explain: There was a stay-away OP against the SS's father in favor of the 3yo SS.	

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
ACS offered the BM bereavement service following the fatality and provided burial assistance. When the PGM was granted temporary custody of the SS, she was offered community-based services on behalf of the SS but the PGM refused.

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:
Due to the SS's age and development, no services were required in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
Bereavement services were offered to the BM; however, it was unknown if services were utilized.

History Prior to the Fatality

Child Information

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/08/2023	Deceased Child, Male, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Other Adult - SS's Father, Male, 30 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 3 Years	Mother, Female, 33 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 33 Years	Educational Neglect	Unsubstantiated	

Report Summary:

An SCR report alleged the BF of the SS dropped the SS off around 7:00PM on 3/8/23 and forcefully hit and injured the BM in the presence of the SS. The SS was not injured. Four subsequent reports were received with concerns regarding the SC's behavior in school and the BM refusing to address this behavior, the SC's academics and attendance, and the SS being left unsupervised resulting in the SS leaving the BM's apartment building on two occasions. The BM was unaware the SS was missing until three hours later.

Report Determination: Indicated	**Date of Determination:** 05/05/2023

Basis for Determination:
ACS unsubstantiated the allegations against the BM. LE reported the BM acted appropriately after the SS left the apartment twice. A chain was placed on the apartment door. The BM was available for the SC's school as needed and the SC's attendance improved. The BM called LE when the SS's BF assaulted her and the SC. The SS's BF was determined not to be a person legally responsible for the SC. The allegation against the SS's BF regarding the SS was substantiated, due to the BF assaulting the BM and SC in the presence of the SS. The BF was arrested, and an OP was issued on behalf of the SS.

OCFS Review Results:
ACS initiated their investigation within 24 hours by conducting a home visit and assessing the safety of the CHN. Documentation was completed timely. The record did not reflect necessary collaterals were contacted, including the SS's audiologist to confirm the SS attended his appointment. LE was not informed the SC was punched by the SS's BF during an altercation with the BM. The record did not reflect that MH services were discussed with the BM regarding the SC, despite the SC asking to speak to a therapist and being recommended for counseling after being hospitalized for making threats at school. The RAP did not have an accurate risk rating.

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

Issue:
Appropriateness of allegation determination

Summary:
The SS left the BM's apartment on two occasions within one month while the BM was asleep. The SS wandered blocks away from the home and was located by bystanders. The SS was 3yo and required constant supervision. The record did not reflect the BM took action after the first incident to prevent the SS from getting out again. The allegation of LS was not added or substantiated against the BM.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the New York City Regional Office if further guidance is needed.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
ACS learned that the SS's BF punched the SC in the face during an altercation with the BM. ACS determined the BF was not a person legally responsible for the SC, but the record did not reflect ACS provided this information to LE, who were unaware the SC was involved in the incident. There was no documentation ACS followed up with the SS's audiologist to determine the necessary evaluation occurred.

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

Action:
ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:
Failure to Offer Appropriate Services

Summary:

There were ongoing concerns regarding the SC's behavior in the community and at school, resulting in the SC being arrested and suspended. The SC reported he wished to speak to a therapist and was recommended for counseling services after being evaluated at the hospital for making threatening statements at school. The record did not reflect that MH services were explored with the BM.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, ACS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP did not reflect the BM's failure to meet developmental expectations for the 3yo SS. The BM did not provide consistent supervision which resulted in the SS leaving the BM's home twice. There was no documentation the BM's rental arrears were explored during this case which were documented in a previous RAP from 1/2023. The inclusion of these two factors would affect the overall risk rating.

Legal Reference:

18 NYCRR 432.2(d)

Action:

ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:

Case record contains information that is relevant, useful, factual and objective

Summary:

Multiple interview notes appeared to have sections regarding conversations with the BM and assessment of the home copied from previous interviews and investigations.

Legal Reference:

18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:

ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/28/2022	Deceased Child, Male, 13 Years	Other Adult - SS's Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 2 Years	Other Adult - SS's Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 2 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	

	Sibling, Male, 2 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated

Report Summary:
The SCR report alleged the BM and BF of the SS regularly got into violent physical altercations in the presence of the CHN. Both CHN were aggressive toward each other. The SC was violent with the BM and SS. The BM did not address the CHN's aggressive behavior. The SC was defiant, misbehaved in school, and smoked marijuana. The BM was unable to control the SC. The BM sold her food stamps for money to buy alcohol, marijuana, and other things. There was often no food in the home and the CHN were hungry. The SS was developmentally delayed and mostly nonverbal. The BM and BF of the SS did not adequately address the matter.

Report Determination: Indicated | **Date of Determination:** 01/28/2023

Basis for Determination:
ACS substantiated the allegation of IG against the BM. The BM was aware the SS had a speech delay and was nonverbal but failed to make the SS available for an evaluation, despite attempts to contact her. The BM did not address the SC's behaviors occurring in school and the community. The SC had poor attendance, was arrested for stealing at knifepoint, and threatened to bring a knife to school. The BM was unable to control the SC's behavior. The allegation of IF/C/S was unsubstantiated. The SC and SS had appropriate clothing, food, and appropriate bedding. The allegation of IG was unsubstantiated against the SS's BF as he did not care for the SC and addressed concerns for the SS with the BM.

OCFS Review Results:
ACS initiated their investigation within 24 hours, conducted a home visit and interviewed all household members when age-appropriate. Documentation was completed timely. The record did not reflect attempts to notify, interview, or contact the SC's BF. There was no documentation that concerns regarding the SC's arrest were addressed with the BM. The record did not reflect that all necessary medical collaterals were contacted. The BM was substantiated for IG regarding the SS due to missed appointments for a developmental evaluation; however, the SS had an appointment scheduled for 1/30/23 and the case was closed on 1/28/23 without confirmation if the appointment was attended.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
ACS obtained information that the SC was arrested for stealing a phone at knifepoint. Although a home visit was attempted on the date this occurred, the case was closed the next day before this concern could be addressed with the BM. The concerns regarding a 17yo MU supplying the SC with marijuana were not fully explored, as safety of the 17yo MU was not established.

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

Action:
ACS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an ongoing assessment of safety and risk throughout the length of the investigation.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
ACS predetermined the allegation of IG against the BM regarding the SS. ACS supported their substantiation of IG by stating the BM did not follow through with an evaluation for the SS. While BM did miss previous appointments, the SS had an evaluation appointment scheduled for 1/30/23 and the case was indicated and closed on 1/28/23, prior to confirming if the scheduled appointment was attended.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
ACS will make an adequate assessment of the nature, extent, and cause of any condition which may constitute abuse or

maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The record did not reflect that ACS followed up to confirm the SS attended a necessary appointment with the audiologist that had previously been missed and rescheduled by the BM. There was no documentation ACS obtained discharge documents after the SS was hospitalized for a viral infection reported by his BF and PGM.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:
Failure to Offer Appropriate Services
Summary:
While the record did reflect DV, substance misuse, and MH services were offered regarding the BM, there was a documented service need regarding the SC's MH that was not addressed. The SC had excessive absence, there were concerns about his behavior in school, and he had been arrested for stealing at knifepoint; however, the record did not reflect the SC's MH needs were explored with the BM.
Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)
Action:
Based on the investigation and evaluation conducted, ACS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The record did not reflect attempts to contact, notify, or interview the SC's BF, despite supervisory notes reflecting contact needed to be made to explore the nature of conversations between the SC and his BF. The BF was incarcerated but had regular phone contact with the SC.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
ACS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/12/2022	Deceased Child, Male, 13 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The SCR report alleged that on 9/12/22, the BM failed to make an appropriate plan for the SC's care. As a result, the SC was left alone and unsupervised for several hours.

Report Determination: Unfounded | **Date of Determination:** 11/02/2022

Basis for Determination:
ACS unsubstantiated the allegation of IG against the BM. The BM was home at the time the SC was supposed to be dropped off by the bus from school and the BM and SC had agreed the SC would go to the park after being dropped off and would notify the BM by ringing the apartment intercom once; therefore, the BM did not go downstairs to retrieve the SC. The BM did not have a working phone and therefore was unable to be reached. The BM and SC reported this was the first time an incident like this happened and BM stated she has not had issues with the previous bus company. The BM addressed the concern by signing a consent form allowing the SC to be dropped off upon arrival to the case address.

OCFS Review Results:
ACS initiated their investigation within 24 hours by contacting the source of the report and conducting a home visit. Multiple home visits occurred during the investigation and all household members were interviewed when age appropriate. Documentation was completed timely. The record did not reflect interviews or attempted contact with the SC or SS's respective BFs. There was no documentation that concerns regarding the SS's medical care were addressed with the BM prior to case closure.

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

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)
Summary:
Concerns regarding LMC for the SS were discovered during the investigation. While this was discussed with the SS's medical provider and the SS had an upcoming appointment, the record did not reflect the concerns were addressed with the BM.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(d)
Action:
ACS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
The record did not reflect attempts to notify, interview, or contact the SC or SS's respective BFs, despite documentation that the SC had regular phone contact with his BF and supervisory notes advising ACS to contact the BFs.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
ACS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/20/2021	Deceased Child, Male, 12 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 12 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Male, 1 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 12 Years	Other Adult - SS's Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 12 Years	Other Adult - SS's Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 1 Years	Other Adult - SS's Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 1 Years	Other Adult - SS's Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 12 Years	Mother, Female, 31 Years	Lack of Supervision	Unsubstantiated

Report Summary:
An initial SCR report alleged the BM and SS's father abused marijuana daily and became impaired while caring for the CHN. The parents left the drugs out and accessible to the CHN. It was unknown if the CHN accessed the drugs. The BM was unable to adequately manage the SC's behaviors. The SC stole money from the BM, was acting out, and not listening. As a result, the BM forced the SC out of the home for excessive periods of time and did not make a plan for him. Multiple subsequent and duplicate reports were received that were merged into the initial case. The subsequent reports alleged the SS's father assaulted the BM in the presence of the CHN and the BM's new partner (PS) punched the SC.

Report Determination: Unfounded | **Date of Determination:** 01/19/2022

Basis for Determination:
ACS unsubstantiated the allegations. The BM reported the PS did not hit or mistreat the SC or SS and denied DV with the PS. The SC reported feeling happy about the BM being in a relationship with the PS and stated he and SS were treated well. The BM admitted to occasional marijuana and alcohol use, but there was no observation of drug paraphernalia. The SC denied substance use in the home. ACS' Investigation Conclusion notes that the allegations against the SS's father were not about him, but about the PS; however, there was a subsequent report called in regarding the SS's father assaulting the BM. The outcome of these allegations was not reflected in the conclusion.

OCFS Review Results:
ACS initiated their investigation by attempting contact with the source of the report and attempting a home visit. ACS interviewed all household members and subjects of the report when age-appropriate. ACS completed documentation timely. The record reflected an ongoing concern regarding the SC's school attendance; however, there was minimal intervention by ACS regarding this continued issue.

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

Issue:
Appropriateness of allegation determination

Summary:
ACS inaccurately unsubstantiated the allegation of IG against the SS's BF. He physically assaulted the BM and tried forcing his way into her home. The BM recorded this incident and filed a police report. The SC witnessed part of the incident and reported being scared due to thinking the SS's BF was going to hit the BM. The SC reported the SS was crying and he had to move the SS to another room.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the New York City Regional Office if further guidance is needed.

Issue:

Case record contains information that is relevant, useful, factual and objective

Summary:

The allegations of IG and PD/AM were incorrectly merged to the SS's father. ACS determined the allegations were regarding the PS; however, the appropriate allegations were not added against him and therefore the necessary determination of those allegations was not made.

Legal Reference:

18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:

ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

The record did not reflect attempts to contact a PA or the father of the SC regarding the allegations that the BM had called them and informed them the SC was physically assaulted by the PS.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

ACS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/22/2021	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 11 Months	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 11 Years	Other Adult - SS's Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 11 Months	Other Adult - SS's Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 11 Years	Mother, Female, 30 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 11 Months	Mother, Female, 30 Years	Lack of Supervision	Unsubstantiated	

Report Summary:

The SCR report alleged the BM drank alcohol on a daily basis. When impaired by alcohol, the BM engaged in physical altercations with the BF of the SS in the presence of the CHN. The BM left the CHN home alone, for hours at a time, without adult supervision. The SC was not mature or responsible enough to handle caring for the SS.

Report Determination: Unfounded | **Date of Determination:** 04/05/2021

Basis for Determination:

ACS unsubstantiated the allegations against the BM and the BF of the SS stating there was no evidence the BM failed to meet a minimum standard of care that placed the CHN in imminent danger or harm. The BM and SC denied the SC being left home alone with the SS. The SC and BM denied the SC touching or acting inappropriately with the SS. The SC denied drug or alcohol use in the home, and the BM was observed to be sober. The BM and BF of the SS had no contact,

and therefore there was no evidence of ongoing DV. Collateral sources reported no concerns for the BM's care of the CHN.

OCFS Review Results:
ACS initiated the investigation within 24 hours, contacted the source, conducted a home visit, and interviewed household members. All documentation was completed timely. ACS was in regular contact with the SC's school to address ongoing concerns regarding the SC's attendance and engagement with remote learning. The record did not reflect the SS's father, who was named as a subject of the report, was interviewed face-to-face and was only spoken to via phone. The SC's father was noted to be incarcerated; however, the record did not reflect this was confirmed or any attempts to contact, notify, or interview that father. There was no documentation safe sleep guidelines were reviewed with the BM.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The record did not reflect the SS's father, who was named as a subject of the report, was interviewed face-to-face. The father was only interviewed via phone. The record did not reflect attempts to contact, interview, or notify the SC's father.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Issue:
Failure to provide safe sleep education/information

Summary:
While the record did reflect ACS reviewed safe sleep guidelines with the PGM, there was no documentation that safe sleep guidelines were reviewed with the BM.

Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:
ACS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/05/2020	Deceased Child, Male, 11 Years	Other Adult - SS's Father, Male, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 5 Months	Other Adult - SS's Father, Male, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged on 3/17/20, the father of the SS punched the mother and pushed her into a wall while she was holding the SS. The SC was also present in the room at the time. The BM's role was unknown.

Report Determination: Unfounded | **Date of Determination:** 10/26/2020

Basis for Determination:
The BM and father of the SS admitted to having frequent verbal disputes but denied they ever escalated to physical disputes. The BM denied the SS and SC were present; however, the father of the SS admitted the SS and SC were present

in the room but could not hear the dispute. LE records reflected the BM reported the father of the SS attacked her while she was holding the SS, and that the SS's BF hit the BM multiple times, grabbed her, and threw her against a closet. The SS's BF created a hostile environment which placed the SS at risk. ACS initially substantiated the allegations of IG against the SS's BF; however, the determination was overturned at a fair hearing.

OCFS Review Results:
ACS initiated their investigation within 24 hours by attempting contact with the source and attempting home visits. ACS interviewed household members, subjects of the report, and collateral sources. ACS addressed newly identified concerns and referred the family to appropriate services. The SC's father was incarcerated at the time of the report; however, the record did not reflect attempts to contact, interview, or notify him.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
Although ACS was aware the SC's father was incarcerated during the investigation; the record did not reflect attempts to contact, interview, or notify the father despite the SC being listed as a maltreated child on the report.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 01/27/2023

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☐	☒	☐	☐
Did all service providers comply with mandated reporter requirements?	☐	☐	☐	☒
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Explain:
Not all services were offered or followed-up on, including the SS's medical and developmental needs and MH counseling for the SC.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☐	☒	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Required Action(s)

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

Issue:	Provide preventive services according to the needs of the child and the child's family
Summary:	The SC needed MH services prior to his death; however, the record did not reflect MH services were discussed with the BM. The SS needed an evaluation for his speech delay, but there was no documentation ACS followed up with the BM about this concern.

Legal Reference:	18 NYCRR 423.4(a); SSL 424 (13)
Action:	Preventive services shall be provided according to the needs of the child and their family.
Issue:	Adequacy of Preventive Services casework contacts
Summary:	There was no casework activity or contact documented from 1/30/23 to 5/5/23. The SC was not assessed during the open services case prior to ACS learning of his disappearance and death. The SS was not assessed until 5/16/23, after the SC disappeared.
Legal Reference:	18 NYCRR 423.4(c)(1)(ii)(d)
Action:	In cases where the child protective service is the primary service provider to children named in indicated child protective services cases and their families, ACS must make at least two separate face-to-face contacts per month with the subject(s) and other persons named in the report, one of which one must take place in the subject's home.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The record did not reflect ACS spoke to LE regarding information surrounding the SC's death, including that a third child was present and possibly got into an altercation with the SC resulting in him falling into the river.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will make diligent efforts to contact collaterals to potentially gather outside information.
Issue:	Adequacy of Child Protective Services casework contacts (open services)
Summary:	Interviews with the BM lacked key safety-related questions pertaining to the BM's actions following the SC's disappearance. There was insufficient information to determine if there was suspected abuse or maltreatment by the BM, including LS.
Legal Reference:	18 NYCRR 432.2(b)(4)(vi)
Action:	ACS will gather sufficient information during casework contacts to establish if there is suspicion of suspected abuse or maltreatment.

Preventive Services History

A services case was opened from 4/18/2017 to 6/20/17 following an indicated report from 2/2017 regarding the BM's marijuana use affecting her ability to meet the SC's educational needs. The BM engaged in substance abuse treatment and was referred to community-based services.

There was an open services case from 10/2020 to 11/2022 due to DV perpetrated by the SS's father in the presence of the SC and SS. An OP was put in place against the SS's BF and DV services were offered. He was referred to community-based services. A neglect petition was filed against the SS's BF but dismissed without a finding and court-ordered supervision was terminated. The BM declined further services.

There was an open services case at the time of the SC's death, which opened on 1/27/2023 due to concerns regarding the SC's high-risk behavior at school and in the community. There was additional concern regarding the historical and recent history of DV perpetrated by the SS's father, in which he assaulted the BM and SC, as well as concerns regarding the medical and developmental needs of the SS. There was a lapse in casework from 1/30/2023 to 5/5/2023, in which no services were provided, and no casework contact was made. The SC was not assessed during this open services case. The SS was not assessed until 5/16/23. The SS's PGM was granted custody of the SS and refused services after the SC's death.

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