NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-028 **Prepared by: New York City Regional Office**

Issue Date: 11/13/2015

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

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 04/17/2015
Initial Date OCFS Notified: 04/21/2015

Presenting Information

The SCR report alleged that the sixteen-year-old child was shot and killed on 4/17/15. The child was the fifth member of his family to be shot in the past several months, and the second one to have died as a result. These shootings are believed to be gang related. Up until about two months prior to his death, the child resided with his father, until a shooting in that home forced them to leave. From that point until his death, neither father nor the mother had any idea of the child's whereabouts, and they did not file a missing persons report or do anything else to find the child. The report alleged that the lack of supervision, history of extreme violence towards the family, and the parents' inaction contributed to the child's death. The five other children in the home had unknown roles.

Executive Summary

The sixteen-year-old male child died on 4/17/15. As of 10/19/15, NYCRO has not yet received the ME's report. The ME informed ACS that the cause of death was listed as gunshot wound to the pelvic area and the manner as homicide.

The 4/21/15 SCR report included the allegations of DOA/Fatality, IG and LS of the child by the parents.

ACS' investigation showed that on 4/17/15, the child and his thirteen-year-old male cousin were in the courtyard of a New York City Housing Authority (NYCHA) building in Brooklyn when they were shot by two male individuals. At 7:09 PM, EMS/FDNY received information about the shooting incident; they responded to the scene and transported the child and cousin to separate hospitals. At 7:28 PM, the child arrived at the hospital where he was pronounced dead. ACS did not contact the hospital's attending physician. The cousin received medical care for his injuries and was subsequently discharged to his parent. On 4/22/15, the SCR registered a report which included the allegations of II, IG and LS of the cousin by his mother. ACS investigated and unsubstantiated the allegations of this report.

Regarding the subject child, ACS found that a few weeks prior to 4/17/15, the mother sent him to reside with the father. The child went to the father's home but did not remain at that location. The mother did not inform the father that the child would be residing with him, and for about two weeks, the parents did not supervise or monitor the child's activities. ACS addressed the concern of possible gang association. ACS did not find evidence to establish that the child had any gang affiliation. Also, ACS addressed with NYCHA management the issue of the family's safety in the community. ACS staff was informed that as a result of the shooting incident, the family was offered an opportunity to relocate elsewhere. However, the mother declined an initial housing transfer and she said the location was not in close proximity to the family's support system.

ACS reviewed medical records which showed the mother missed several medical appointments for three of the surviving siblings who had pre-existing medical conditions. Also, the school records showed all the children had significant school absences and lateness and the parents had not addressed this issue. On 4/22/15, ACS opened the Family Services Stage and provided the family with PPRS services. ACS held a Child Safety Conference (CSC), reviewed concerns about supervision, and the medical and educational needs of the children. ACS and the parents developed a service plan.

On 5/20/15, LE informed ACS that an arrest was made on 5/12/15 and the suspect was charged with Murder, Attempted Murder and Criminal Possession of a Firearm. Also, ACS maintained ongoing contact with the ME; however, the ME did not provide the autopsy report.

On 7/15/15, ACS substantiated the allegations of IG of the SC by the parents on the basis that the parents failed to take appropriate action to ensure that the child's whereabouts were known at all times. Two weeks prior to 4/17/15, the child left the father's home and the parents apparently had little knowledge of the child's whereabouts. The parents were unaware that the child was three blocks away from the mother's home. ACS also added that the parents' lack of knowledge of the child's whereabouts on the day he was fatally shot indicated that they failed to provide a minimum degree of care to the child.

ACS substantiated the allegation of LS of the SC by the parents. ACS noted that the parents failed to keep track of the SC's whereabouts, and this lack of monitoring placed the SC at risk of harm. The parents admitted they were not aware of the SC's location or activities for a two-week period.

ACS unsubstantiated the allegation of DOA/Fatality of the SC. ACS noted that the SC and surviving cousin were the victims of a random shooting incident in which the SC was fatally shot in a public location.

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:
None.

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:
None.

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: 04/17/2015 **Time of Death:** 08:07 PM

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: 07:09 PM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Other	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	43 Year(s)

LDSS Response

On 4/21/15, the Specialist interviewed EMS/FDNY personnel who said on 4/17/15, at 7:09 they received a telephone call about the child and they responded to the scene. The EMS staff said at about 7:30 PM., the child and cousin arrived at separate hospitals. The child was pronounced dead in the hospital.

According to ACS' case record, the surviving cousin received treatment for his injuries and was released to his mother. ACS' staff visited the cousin's home and engaged his mother who said due to the cousin's injuries he was officially enrolled in a home schooling program. ACS conducted an investigation and determined the mother provided the cousin with adequate care.

ACS' staff observed and interviewed the deceased child's mother, surviving siblings and niece. The mother said, during the two-week period prior to 4/17/15, she believed the child was under the father's supervision. She did not contact the father to verify the child's whereabouts. She said following the 4/17/15 shooting incident, she learned that the child and cousin had been visiting a friend when they observed a male individual had a gun. The mother said the cousin was shot first and the subject child was shot while attempting to assist the cousin. The mother denied the child had gang affiliation. During the home visits, the Specialist engaged the surviving siblings who willingly discussed their feelings about the child's death. The Specialist observed the siblings did not have marks or bruises.

During an interview with ACS' staff, the father said the incident was probably an accidental shooting. The father did not reside with the mother and children and he acknowledged that during the two-week period prior to 4/17/15, he was unaware of the child's whereabouts. The father denied drug use and said he did not have a mental health condition. He also denied he was involved in any domestic violence incidents.

ACS addressed the concerns resulting from other shooting incidents which the family experienced in 2014 and 2015 (prior to the child's death). The mother said as a result of these shooting incidents, four of their relatives had sustained injuries and one family member died. ACS discussed the concerns with LE and housing management who initiated approval for an emergency housing transfer to a different building.

On 4/23/15, ACS held a Child Safety Conference (CSC) and discussed parental supervision, safety in the community pertaining to the child's death, and the children's medical and educational needs. During the CSC, the mother stressed that she had been unable to control the child and she had relied on the father to guide and supervise him. Regarding the school attendance, ACS noted that the family's multiple relocations to homeless shelters and the significantly long commute to school had a negative impact on the children's attendance. The Specialist documented that the children continued to receive support services in school.

ACS attempted to file an Article Ten Neglect petition in Kings County Family Court alleging IG and LS of the surviving children by the parents. The Family Court deferred the petition with directives for ACS to obtain updated school records. ACS reviewed the school records and on 5/27/15, ACS noted that the children had improved attendance and they were being promoted to the next grades.

On 6/5/15, ACS substantiated the allegations of IG, and LS of three children by the father, stemming from a 4/7/15 SCR report. This report pertained to an unrelated shooting incident.

ACS provided the family with PPRS services. The Community Counseling and Mediation (CCM) agency was assigned case planning responsibility. The CCM Family Services Progress Notes showed the mother successfully completed all

recommended services. She accompanied the children to and from school, utilized family or other individuals as safety resources, followed-up with the children's needs, and participated in therapeutic counseling.

Official Manner and Cause of Death

Official Manner: Homicide
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 investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: The investigation adhered to previously approved protocols for joint investigation.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
016421 - Deceased Child, Male, 16 Yrs	016701 - Mother, Female, 43 Year(s)	Lack of Supervision	Substantiated
016421 - Deceased Child, Male, 16 Yrs	016702 - Father, Male, 43 Year(s)	Lack of Supervision	Substantiated
016421 - Deceased Child, Male, 16 Yrs	016701 - Mother, Female, 43 Year(s)	DOA / Fatality	Unsubstantiated
016421 - Deceased Child, Male, 16 Yrs	016701 - Mother, Female, 43 Year(s)	Inadequate Guardianship	Substantiated
016421 - Deceased Child, Male, 16 Yrs	016702 - Father, Male, 43 Year(s)	Inadequate Guardianship	Substantiated
016421 - Deceased Child, Male, 16 Yrs	016702 - Father, Male, 43 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:

The ACS case record did not include information to verify whether the agency obtained information from the hospital attending physician who pronounced the child dead.

There were progress notes which were not entered within the 30-day timeframe.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

Legal Activity Related to the Fatality

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

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
05/12/2015	Suspect	Unknown	Informaiton not found in case record
Comments:	According to the ACS case record, a suspect was arrested on 5/12/15 and the suspect was charged with Murder, Attempted Murder and Criminal Possession of a Firearm.		

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
The family received PPRS services which included case management.

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 mother accepted ACS' offer for bereavement counseling and PPRS services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother and surviving children received bereavement counseling, burial assistance, family violence victim counseling, and housing transfer assistance. The mother did not accept an initial offer for housing transfer. The mother stated that the proposed location was not in close proximity to her support system. The father declined ACS' offer of

services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	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)	Status/Outcome	Compliance Issue(s)
11/19/2013	2716 - Deceased Child, Male, 14 Years	2715 - Father, Male, 40 Years	Educational Neglect	Unfounded	Yes
	2716 - Deceased Child, Male, 14 Years	2724 - Mother - Niece, Female, 42 Years	Educational Neglect	Unfounded	

Report Summary:
The 11/19/13 SCR report alleged the fourteen-year-old child had 41 absences from school and was failing as a result. The report also alleged mother was aware and she failed to intervene.

Determination: Unfounded | **Date of Determination:** 01/17/2014

Basis for Determination:
ACS unsubstantiated the allegation of EdN of the child by the mother on the basis of a lack of evidence to support the allegation that it was the mother's fault the child was not attending school. ACS noted the mother had been proactive with trying to get the child to attend school.

Also, ACS added to the report and unsubstantiated the allegation of EDN of the child by the father. ACS noted there was a lack of evidence to support the allegation. ACS added that the father did not reside in the child's home.

OCFS Review Results:
ACS' staff engaged the family members and assessed that the mother addressed the child's educational needs. The child returned to school and on 12/12/13, the mother and child participated in a school conference in which the school provided educational options. On 1/16/14, ACS noted the child no longer attended school. However, ACS did not follow-up regarding the child's activities, parental supervision and the father's role. ACS did not assess the safety of the 17-year-old sibling within 24 hours.

The physician did not respond to ACS' requests for records. ACS obtained a medical consultation and also directed the case planner to continue monitoring the education and health needs.

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

Issue:
Predetermination/Assessment of Current Safety and Risk

Summary:
The Risk Assessment Profile was inappropriately completed as it did not reflect the family's history of unstable housing and homelessness.

Legal Reference:
18 NYCRR 432.1(aa)

Action:
ACS must meet with the staff involved in this fatality investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Diligence of Efforts

Summary:
In an Investigation Progress Note dated 1/9/14, ACS noted there was no contact information available for the father. Also, ACS added to the 11/19/13 report and unsubstantiated the allegation of EdN of the child by the father. However, the ACS case record did not reflect ACS made diligent efforts to contact the father.

Legal Reference:
NYCRR 430.12D

Action:
ACS must meet with the staff involved in this fatality investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/25/2015	2691 - Deceased Child, Male, 15 Years	2692 - Mother, Female, 43 Years	Educational Neglect	Indicated	Yes
	2691 - Deceased Child, Male, 15 Years	2692 - Mother, Female, 43 Years	Inadequate Guardianship	Indicated	
	2691 - Deceased Child, Male, 15 Years	3111 - Father, Male, 39 Years	Educational Neglect	Indicated	
	2691 - Deceased Child, Male, 15 Years	3111 - Father, Male, 39 Years	Inadequate Guardianship	Indicated	
	3123 - Sibling, Female, 9 Years	2692 - Mother, Female, 43 Years	Educational Neglect	Indicated	
	3123 - Sibling, Female, 9 Years	2692 - Mother, Female, 43 Years	Inadequate Guardianship	Indicated	
	3124 - Sibling, Male, 12 Years	2692 - Mother, Female, 43 Years	Educational Neglect	Indicated	
	3124 - Sibling, Male, 12 Years	2692 - Mother, Female, 43 Years	Inadequate Guardianship	Indicated	
	3125 - Other Child - Niece,	2692 - Mother,	Educational	Indicated	

Female, 11 Years	Female, 43 Years	Neglect	
3125 - Other Child - Niece, Female, 11 Years	2692 - Mother, Female, 43 Years	Inadequate Guardianship	Indicated
3126 - Sibling - Niece, Female, 11 Years	2692 - Mother, Female, 43 Years	Educational Neglect	Indicated
3126 - Sibling - Niece, Female, 11 Years	2692 - Mother, Female, 43 Years	Inadequate Guardianship	Indicated
3127 - Sibling - Niece, Female, 10 Years	2692 - Mother, Female, 43 Years	Educational Neglect	Indicated
3127 - Sibling - Niece, Female, 10 Years	2692 - Mother, Female, 43 Years	Inadequate Guardianship	Indicated
3123 - Sibling, Female, 9 Years	3111 - Father, Male, 39 Years	Educational Neglect	Indicated
3123 - Sibling, Female, 9 Years	3111 - Father, Male, 39 Years	Inadequate Guardianship	Indicated
3124 - Sibling, Male, 12 Years	3111 - Father, Male, 39 Years	Educational Neglect	Indicated
3124 - Sibling, Male, 12 Years	3111 - Father, Male, 39 Years	Inadequate Guardianship	Indicated
3125 - Other Child - Niece, Female, 11 Years	3111 - Father, Male, 39 Years	Educational Neglect	Indicated
3125 - Other Child - Niece, Female, 11 Years	3111 - Father, Male, 39 Years	Inadequate Guardianship	Indicated
3126 - Sibling - Niece, Female, 11 Years	3111 - Father, Male, 39 Years	Educational Neglect	Indicated
3126 - Sibling - Niece, Female, 11 Years	3111 - Father, Male, 39 Years	Inadequate Guardianship	Indicated
3127 - Sibling - Niece, Female, 10 Years	3111 - Father, Male, 39 Years	Educational Neglect	Indicated
3127 - Sibling - Niece, Female, 10 Years	3111 - Father, Male, 39 Years	Inadequate Guardianship	Indicated

Report Summary:
The 3/25/15 SCR report alleged the fifteen-year-old child had not yet attended school since September 2014. The child missed 115 days of school, failed as a result, and fell further behind his peers. The mother failed to respond to the school's outreach. The school staff made home visits, left multiple telephone messages and sent out letters. The mother made no efforts to contact the school. The mother failed to take effective steps to get the child to school and failed to assure the child received an education. The roles of the siblings were unknown.

Determination: Indicated | **Date of Determination:** 05/28/2015

Basis for Determination:
ACS substantiated the allegations of EdN and IG of the child by the mother. ACS noted that the mother did not take appropriate actions to ensure the child attended school and as a result the child engaged in out of control behaviors that resulted in him being a victim of homicide. The mother’s inability to ensure the child’s whereabouts were known at all times indicated she was unable to control him thereby placing him at risk.

ACS added and substantiated the allegations of EdN and IG of the child by the father and of the surviving school-aged children by the parents. The parents did not address the school attendance issue thereby placing the children in jeopardy of failing classes.

OCFS Review Results:
ACS reviewed school records which showed the children were absent at least 17 days and late between 38 and 76 days. The mother said she was unable to manage the child's behavior and she said she sent him to live with the father. On 3/27/15, ACS staff interviewed the child who denied gang involvement and agreed to return to school. He remained truant and ACS did not initiate a safety plan and legal action. On 4/15/15, ACS staff interviewed the father and child and learned that the child refused to disclose his residence. ACS' supervisor advised the Specialist to direct the parents to contact 911 if the child did not return home. On 4/20/15, the mother informed ACS of the child's death.

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

Issue:
Appropriateness of allegation determination
Summary:
ACS added to the report and substantiated the allegations of EdN and IG of the surviving children by the parents. However, the 5/22/15 Investigation Progress Notes showed as of 4/27/15, the surviving children were not at risk of repeating their respective grades. The ACS case record did not include other updated information to determine whether these children continued to fail classes.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue:
Provision of Notice of Indication
Summary:
The CONNECTIONS record showed ACS did not provide the Notice of Indication to the parents who were the subjects of the 3/25/15 report.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS must meet with the staff involved in this fatality investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Assessment as to need for Family Court Action
Summary:
On 4/15/15, ACS noted that the Specialist will direct the parents to contact 911 if the child did not return home. Also, ACS had information about the difficulty the parents experienced in managing the child's behavior. However, the case record did not reflect whether ACS assessed the need for Family Court action.
Legal Reference:
18 NYCRR 432.2(b)(3)(vi)
Action:

ACS must meet with the staff involved in this fatality investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action 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:
ACS inappropriately completed the 3/30/15 safety assessment. In this safety assessment, ACS selected the Safety Decision which stated there was no Safety Factor which actually placed the child in immediate or impending danger of serious harm. However, ACS did not identify that the parents ongoing failure to monitor the child's activities actually placed the child in immediate danger of harm.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
ACS must meet with the staff involved in this fatality investigation and inform the NYCRO of the date of the meeting, who attended, and what was discussed. ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address this issue.

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

Between 5/4/04 and 1/26/12, the family was known to the SCR and ACS in ten reports. Of the total of ten reports, eight were indicated and two were unfounded.

The 5/4/04 and 5/7/04 reports included the allegations of II, IG, L/BW and LS of the deceased child's niece (now eleven-year-old). This child's parents were listed as the subjects of the report. The mother was listed as having "No Role." Subsequently, ACS verified that on 4/13/07 the mother was granted custody of this child.

The 12/15/05 and 4/28/06 reports included the allegations of IG, MN, and IF/C/S of the children who resided in the mother's household. ACS unsubstantiated the allegations of these reports. ACS offered the family PPRS services to address housing, medical and educational needs. The family declined ACS' offer; however, they received case management services through the Department of Homeless Services.

The 1/16/08, 4/7/08, 6/17/08, 9/15/09, 10/27/09 and 1/26/12 reports included the allegations of EdN, IG, MN, IF/C/S and XCP of the children. The parents were listed as the subjects. ACS substantiated the allegations of EdN, IG and MN. ACS unsubstantiated the allegation of XCP. On 2/16/12, ACS filed an Article Ten Neglect petition in Kings County Family Court. The allegations were MN, EdN and IG of the children by the mother. The family received Court Ordered Services.

Known CPS History Outside of NYS

The family had no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

As a result of the 1/16/08 report, ACS found the family had unstable housing, the mother did not monitor the children's education and medical needs. On 2/20/08, ACS opened the Family Services Stage to provide PPRS to the family. The Brooklyn Bureau of Community Services (BBCS) agency was assigned case planning responsibility. The family received family and individual counseling, parenting education and advocacy for health, education and housing needs. The family relocated to a permanent home and the case planner assessed there was no safety concern. On 4/16/09, BBCS closed the case after the service plan goals were achieved.

Between 2/20/12 and 5/15/13, the family received COS after ACS filed and an Article Ten Neglect petition. The family experienced housing problems and consequently relocated to a homeless shelter apartment. Although the housing remained unstable, the mother improved her monitoring of the children's medical and educational needs. The mother informed the case planner of her inability to manage the subject child's behavior. In May 2013, the COS ended and the case was transferred to the Catholic Charities agency who provided case management. Although, the child continued to be truant, on 12/2/14, the PPRS agency closed the case: reason, the children were not at risk of placement. The quantity of casework contacts were adequate for the program requirement.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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