Report Identification Number: NY-17-041

Prepared by: New York City Regional Office

Issue Date: Nov 01, 2017

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Jurisdiction: Richmond
Date of Death: 03/17/2006
Age: 2 year(s)
Gender: Male
Initial Date OCFS Notified: 04/26/2017

Presenting Information

On 4/26/17, the SCR registered a report alleging the mother had a 2-year-old child who died 10 years ago.

The report alleged the SC climbed on a television stand and due to his weight, both the television and the SC fell to the ground. As a result, the SC sustained fatal injuries. The report alleged that due to this tragedy, the mother had clinical issues, but did not want clinical treatment.

The report alleged the mother was currently the sole caretaker for her 8-year-old sibling and unable to make adequate decisions in regards to the care, safety, or supervision of the child due to her clinical issues and current drug use.

The report also alleged the mother drove the 8-year-old child to school while under the influence of illegal drugs. The report further alleged the sibling had attendance problems and as a result the child was failing.

Executive Summary

The death of this 2-year-old SC was originally reported on 3/17/06 when it occurred. The autopsy report listed the cause of death as skull fractures with subdural hemorrhage due to blunt impact and the manner of death as accidental (hit by television that fell off the night stand).

OCFS previously issued a fatality report (95-06-016) regarding ACS' investigation of the fatality. The allegations of the report were DOA, L/B/W, II and IG of the SC by the parents. The report was indicated. ACS addressed the citations concerning the timeliness of the investigation determination and interviews with relevant collateral contacts.

At the time of the fatality, the SC had one sibling who is now 15 years old. In 2008, the parents had another child who is currently 8 years old.

On 4/26/17, the SC's death was again reported to the SCR for allegations of DOA and IG, and PD/AM, EdN and IG of the 8-year-old sibling by the mother.

On 6/9/17, ACS substantiated the allegations against the mother for the DOA and IG of the SC and unsubstantiated the allegations of PD/AM, EdN and IG of the 8-year-old sibling.

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:
N/A

Was the decision to close the case appropriate? Unknown

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

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
N/A

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? X Yes __No

Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS selected safety decision (2) which notes there were safety factors present, but did not rise to the level of immediate or impending danger of serious harm. However, the investigation documentation did not support this decision.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Failure to provide notice of report
Summary:	The CONNECTIONS' event list reflected the NOE was not issued for the father.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	ACS did not utilize the information gathered to make the determination for EDNG. ACS failed to substantiate the allegation of EDNG of the 9 year-old sibling. Also, ACS did not add and substantiate the allegation EDNG for the 15-year-old sibling.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS selected safety decision (2) which notes there were safety factors present, but they did not rise to the level of immediate or impending danger of serious harm. However, the investigation documentation did not support this decision.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	ACS made no effort to contact the father or paternal relatives to assess whether they could assist with the children's school attendance and/or academic performance.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	According to the mother, the father was "co-parenting" and involved in the siblings' lives. The 15-year old sibling stated he saw his father everyday. Yet, ACS failed to list the father in the RAP as the secondary caretaker.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/17/2006 **Time of Death:** 12:43 PM

County where fatality incident occurred: Richmond

Was 911 or local emergency number called? Yes

Time of Call: 12:11 PM

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? No

Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: watching television

Did child have supervision at time of incident leading to death? No - but needed

At time of incident supervisor was:

- Drug Impaired
- ☐ Alcohol Impaired
- ☒ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☐ Asleep
- ☐ Impaired by illness
- ☐ 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	2 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	78 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)

LDSS Response

ACS initiated the investigation within the required time frame and assessed the siblings were safe in the care of the mother and the MGF who also resided in the home. The mother stated the father no longer resided with the family, but continued to be involved with the children. The mother did not have contact information for the father, and ACS did not make any effort to contact the father or issue a NOE for him.

The mother refused to discuss the allegations of DOA or IG of the SC because she did not find it was relevant to the current allegations concerning the 8-year-old sibling.

ACS contacted the school staff who stated that on 4/26/17, the mother dropped off the 8-year-old sibling at school and was later found sleeping in her car. The mother was approached by the school staff and said she was tired then left the premises. The staff said the mother did not appear to be under the influence of alcohol or drugs.

The mother said she dropped off the 8-year-old sibling at school and then parked her car to wait for a phone call which she expected to receive within the next 10 minutes. The mother said she waited in the car to avoid talking while driving. The mother said she was exhausted because she had not slept well the past two days and dosed off. The mother denied any use of drugs. The mother submitted to drug screenings twice and both results were negative.
The mother said the death of the SC was the hardest experience she had endured. The mother declined ACS' offer for bereavement counseling because she had attended counseling after the SC's death but found it too difficult to continue to speak about the loss of the SC.

ACS addressed the siblings' attendance with the mother who stated most absences were "medically related." The mother said she understood the importance of education, but considered the children's health to also be important. ACS contacted the siblings' pediatrician who reported the siblings' immunizations were current and there were no medical concerns for

either child. ACS did not inquire about the number of medical visits or the alleged medical notes provided for their absences.

The 8-year-old sibling's attendance records, from 2015-2016 indicated the child was late 75 times and absent 27 days. During the current school year 2016-2017, the sibling had been late 69 times and absent 27 days.
ACS contacted the 15-year-old sibling's guidance counselor (GC) who reported the sibling had attendance and academic problems. The GC indicated the sibling would have to take two subjects during summer school. ACS did not document this sibling's number of absences or lateness.

The MGF and a MA reported the mother was a good parent and had no concerns about how she cared for the siblings. However, there was no detailed discussion regarding the EdN of the siblings to assess how they could assist the family with improving the siblings' educational and academic needs.

The 15-year-old sibling stated he missed school days because he was 'lazy" and did not like school. The sibling said the mother would "yell to get him to go to school, but he would not listen." The child said he saw his father daily. The Specialist did not inquire about contact information for the father or whether he was aware of the sibling's academic and attendance problems. The sibling stated he had never seen his parents engage in domestic violence incidents nor use drugs or alcohol. The sibling said he did not observed the mother was tired or sad frequently.

On 6/9/17, ACS unfounded the report.

ACS unsubstantiated the allegations of the report, except for EdN. ACS failed to add the allegation of EdN for the 15-year-old sibling and substantiate this allegation for both siblings.

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 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 OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
040023 - Deceased Child, Male, 2 Year(s)	040024 - Mother, Female, 41 Year(s)	DOA / Fatality	Substantiated
040023 - Deceased Child, Male, 2 Year(s)	040024 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Substantiated

040025 - Sibling, Male, 8 Year(s)	040024 - Mother, Female, 41 Year(s)	Educational Neglect	Unsubstantiated
040025 - Sibling, Male, 8 Year(s)	040024 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Unsubstantiated
040025 - Sibling, Male, 8 Year(s)	040024 - Mother, Female, 41 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?				
When appropriate, children were interviewed?				
Alleged subject(s) interviewed face-to-face?				
All 'other persons named' interviewed face-to-face?				
Contact with source?				
All appropriate Collaterals contacted?				
Was a death-scene investigation performed?				
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?				
Coordination of investigation with law enforcement?				
Did the investigation adhere to established protocols for a joint investigation?				
Was there timely entry of progress notes and other required documentation?				

Fatality Safety Assessment Activities

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

Explain:
The 24-Hour and 7-Day Safety Assessments were not properly completed. ACS selected safety decision (2) which notes there were safety factors present, but did not rise to the level of immediate or impending danger of serious harm. However, the investigation documentation did not support this decision, as there were no evident safety factors for the siblings.

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The lack of contact with the father did not allow for a full assessment of his contribution and support to the family. Therefore, concerns pertaining to the children's absenteeism and the mother's clinical issues were not fully assessed.

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
ACS selected safety factors that were not supported by case documentation. In addition, the comments to support the safety factors selected consisted solely of the family's history.

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	Needed but 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:
During the current investigation, the mother said she tried counseling in the past, but found it difficult to continue to speak about the death of the SC.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no immediate services needed for the surviving sibling after the fatality. The SC died in 2006.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate needs for the parents.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	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?	N/A
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

The parents became known as subjects to ACS and the SCR on 3/17/06 when the death of the SC was reported. The allegations of the report were DOA, II, L/B/W and IG of the SC.

According to ACS' investigation, the SC was home with the mother watching television in the parents' bedroom. The mother went to the bathroom and heard a crash. When she returned to the bedroom, she found that a 27" television had fallen from the night stand on top of the SC. The mother called 911 and the SC was transported by EMS to Staten Island University Hospital where he was pronounced dead at 12:43 P.M. ACS found the night stand was both too small and unsteady for the television.

On 7/31/06, the report was indicated and the allegations were substantiated against both parents.

On 11/16/11, the SCR registered a report for allegations of IF/C/S, PD/AM, LS and IG of the two siblings by the parents. On 1/18/12, the report was unfounded and legally sealed.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Preventive Services History

There is no record of Preventive Services 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 X No

Are there any recommended prevention activities resulting from the review? __Yes X No