Child Fatality Report

Report Identification Number: NY-22-014

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

Issue Date: Aug 17, 2022

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased

Jurisdiction: Office Of Special Investigations

Date of Death: 03/07/2022

Age: 3 year(s)

Gender: Female

Initial Date OCFS Notified: 03/07/2022

Presenting Information

An SCR report alleged on 3/7/22, the 3-year-old SC was unresponsive at the foster home. EMS performed CPR and transported the SC to the hospital. A subsequent report alleged the SC was blue and unresponsive with unexplained marks and bruises on her body. The foster mother was the sole caretaker of the SC at the time of her death and did not have an explanation for the SC's demise. The SC had been in the care of the foster mother for approximately 8 months and was observed with unexplained marks and bruises. About a month before the death, the SC was observed with a bruise on her eye and the explanation provided was inconsistent with the injury. In February 2022, the SC had a third degree burn from a hot comb on her arm. A week prior to the death, the SC had a burn on her neck and bruises on her arm. The foster mother did not have an explanation for the SC’s injuries.

Executive Summary

This report concerns the death of the 3-year-old subject child (SC) that occurred on 3/7/22. Two SCR reports were received and alleged the SC was found unresponsive in her bed. The SC was transported to the hospital where she was pronounced deceased. At the time of her death, the SC resided with her foster mother (FM), the foster mother’s partner and their children (ages 2 months, 5 and 12 years). There were two other foster children in the home (ages 3 and 5 years). The foster parents’ children remained in their care and a Preventive Services Case was opened. The foster children were transferred to another foster home, where they were assessed to be safe. A sibling resided with a relative, and had not met the SC.

The Administration for Children Services (ACS) coordinated investigative efforts with LE upon receipt of the SCR reports. An autopsy was performed; however, the final autopsy report was pending at the time this report was written. The ME said the bruising on the SC appeared normal considering her age, and that the death looked “very much like a seizure”; however, could not say with certainty the SC died as a result of a seizure. The criminal investigation was closed without charges.

The FM and her partner reported the day prior to the SC’s death was a normal day. Before going to bed, the SC vomited and then took a shower, followed by taking a bath. While taking a shower, the SC had a temper tantrum. The FM left the SC in the bathroom while she was in the tub and the family checked on her. When the SC’s bath was over, the FM dressed her and then tucked her in bed. In the middle of the night, the FM woke and checked on the children. She found the SC unresponsive and not breathing. The FM called 911 while her partner performed CPR until EMS arrived and took over. The SC was transported via ambulance to the hospital where she was pronounced deceased.

ACS gathered information from collateral contacts including the hospital, the surviving children, a neighbor, a personal collateral contact, the foster care agency and the daycare provider. The neighbor and the personal collateral contact did not have concerns for the care the FM or her partner provided for the children. Foster Care agency staff reported seeing a video of the SC in a seizure-like trance and the SC was seeing a neurologist to figure out what was happening. The SC had not received a medical diagnosis at the time of her death. The daycare provider stated the SC often presented as hungry and reported her concern to the foster care agency. The foster care agency found that the doctor reported the SC was not underweight, there was food in the foster home and the SC appeared happy during visits to the home. The daycare provider did not observe bruises on the SC.

ACS conducted home visits and documented thorough interviews. The Safety Assessments were completed timely; however, were inaccurate. The required reports were completed timely and accurately. The allegation of IG was substantiated against the FM and her partner. ACS determined the FM and her partner were aware the SC had a fear of showers that would result in the SC having tantrums. Despite this, the FM and her partner left the SC unattended in the bathtub unattended for a period of 20-60 minutes. The allegations of B/S and L/B/W were unsubstantiated against the FM. The medical examiner did not find any bruises or burns on the SC that would be a result of abuse or maltreatment. The DOA/Fatality allegation was unsubstantiated. The investigation did not reveal evidence the actions or inactions of the adults contributed to the SC's death.

ACS offered the FM, her partner and the mother of the SC bereavement services, mobile crisis and a referral to the CAC. It remained unknown if the services were utilized. The adults accepted funeral assistance. The surviving children were referred for grief services and were engaged in therapy at the time of case closure.

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:**
  - **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

Was the decision to close the case appropriate? Yes

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

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

Explain:

Casework activity was not commensurate with case circumstances as the Safety Assessments did not accurately reflect case circumstances although the Safety Decision was appropriate.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	Safety Factor #7 was selected and case circumstances did not reflect the adults were unable or unwilling to meet the children's needs for food, clothing, shelter, medical/mental health care nor unable to control the child's behavior.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/07/2022 **Time of Death:** 05:37 AM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 04:49 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 4 Hours
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☒ Asleep ☐ 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	Female	3 Year(s)
Deceased Child's Household	Foster Parent	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Foster Parent	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Other Child - Foster Mother's Child	No Role	Male	12 Year(s)
Deceased Child's Household	Other Child - Foster Parents' Child	No Role	Female	5 Year(s)
Deceased Child's Household	Other Child - Foster Parents' Child	No Role	Male	2 Month(s)
Deceased Child's Household	Other Child - Foster Child	No Role	Male	5 Year(s)
Deceased Child's Household	Other Child - Foster Child	No Role	Male	3 Year(s)
Other Household 1	Mother	No Role	Female	22 Year(s)

LDSS Response

On 3/7/22, ACS received a fatality report from the SCR. A subsequent report was received the next day. Within the first 24 hours of the investigation, ACS coordinated investigative efforts with LE, the ME and district attorney's offices were made aware of the death and the sources of the reports were contacted. A CPS history check was documented, and ACS spoke with a hospital physician. The CHN of the FM and her partner were deemed safe in their care; however, the foster CHN were transferred to another foster home and the foster home was closed.

The hospital physician said when the SC arrived at the hospital, she had no vitals, no bruising and she was cold and limp. The FM told hospital staff the SC had stomach pain on the night of 3/6/22 and she found the SC unresponsive in bed on 3/7/22.

On 3/7/22, the FM was interviewed in the home. The FM said on 3/6/22, the CHN and the adults went out, and returned home around 10:00 PM. When they returned home, the SC complained of stomach pain and vomited. The SC was told to shower as she had vomit in her hair. The SC was afraid of getting water in her eyes, so she had a tantrum and was told she could have a bath after she washed her hair in the shower. The FM assisted the SC in washing her hair and the SC happily got in the tub, which the FM filled to the SC's waistline and left the room. The FM reported checking on the SC about 4-5 times in the 20-minutes she was in the bath. The FM said the SC went underwater, pretending she was swimming and vomited again. The FM also stated the SC turned the cold water on at least twice while in the bath. The FM ended the SC's bath and tucked the SC into bed and the family went to sleep around 12:00 AM. During the night, the FM heard a noise and checked on the CHN. She found the SC lying in bed with her eyes open and in a fixed position. The SC also had wet mucus like vomit stuck to the left side of her face. The SC had a bite mark on her tongue and it was bleeding. She began breathing into the SC's mouth and could see her stomach moving. The FM then took the SC to the shower in an attempt to wake her up. She yelled to her partner, who began CPR while the FM called 911. EMS responded and brought the SC to the hospital.

According to the FM, the SC had 4 "convulsions" monthly, and the SC was physically violent, hitting, and kicking, locked her jaw and curled her hands in. The SC saw a neurologist and her next appointment was scheduled for 3/14/22. ACS spoke with foster care agency and verified the SC saw a neurologist. A social worker verified a doctor witnessed the SC in a "staring episode" in 2021, which prompted the SC to be seen by a neurologist.

The FM's partner said the SC had a tantrum while in the bathroom, so the FM left her alone to calm down. He said about an hour later, the SC came out of the bathroom and appeared to be in a bad mood. According to the partner, the FM went to bed around 1:00 AM and he stayed up. He heard a noise around 3:00 AM which woke up the FM, and that is when she checked on the SC and she was unresponsive. He stated the SC was not diagnosed with a disorder nor was she prescribed medication. The partner stated the SC was accidentally burned with a flat iron while the FM styled her hair and that the SC did not have bruising. The foster agency verified the burn was reported and the SC received appropriate medical treatment

for it.

The surviving CHN were interviewed separately at home and at the CAC. The 5yo foster child said the SC put a hair clip in her mouth and could not breathe. He said the FM called LE and the SC went in an ambulance. He later stated the SC ate glass; however, there was no information to support this. The 12yo child reported the SC was fine the day before her death and that he did not see the SC "convulsing"; however, he saw the SC have a tantrum and he saw CPR performed. The other CHN did not have additional information.

The foster CHN were transferred to another foster home in response to the death. The FM's CHN remained in her care. ACS opened a Preventive Service Case as there were concerns the adults were not providing their 5yo child adequate supervision which was investigated separately after the death.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060834 - Deceased Child, Female, 3 Yrs	061001 - Foster Parent, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
060834 - Deceased Child, Female, 3 Yrs	061002 - Foster Parent, Male, 39 Year(s)	DOA / Fatality	Unsubstantiated
060834 - Deceased Child, Female, 3 Yrs	061001 - Foster Parent, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
060834 - Deceased Child, Female, 3 Yrs	061002 - Foster Parent, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
060834 - Deceased Child, Female, 3 Yrs	061001 - Foster Parent, Female, 31 Year(s)	Burns / Scalding	Unsubstantiated
060834 - Deceased Child, Female, 3 Yrs	061001 - Foster Parent, Female, 31 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐

Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☐	☒
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐

Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

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?	☒	☐	☐	☐
If Yes, court ordered?	☐	☒	☐	☐
Explain as necessary: The surviving children were placed in an alternate Foster Care home as a result of the fatality.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☒	☐	☐	☐	☐	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐

Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The children of the foster parents remained in their care and a Preventive Service Case was opened.

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 children were referred to the Child Advocacy Center for grief counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother, foster mother and her partner were offered mobile crisis services, grief counseling and funeral assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
Were there any siblings ever placed outside of the home prior to this child's death? 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)
07/21/2020	Sibling, Male, 4 Months	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Female, 2 Years	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Months	Aunt/Uncle, Female, 40 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 2 Years	Aunt/Uncle, Female, 40 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Months	Mother, Female, 19 Years	DOA / Fatality	Unsubstantiated	
	Sibling, Male, 4 Months	Aunt/Uncle, Female, 40 Years	DOA / Fatality	Unsubstantiated	

Report Summary:
An SCR report alleged on 7/20/20, the BM co-slept with the 4-month-old deceased sibling (DS). The BM co-slept with the DS placed on a Boppy pillow. The DS was last seen alive between 6:00 AM- 8:00 AM. After feeding the DS, the BM gave him a pacifier and went back to sleep. At 9:00 AM, the BM discovered the DS was not breathing. It was unknown if he was still on the pillow. The BM went into the aunt's room for help. For unknown reasons, the adults delayed calling EMS until 9:50 AM. The aunt performed CPR until EMS arrived and the DS was pronounced deceased at 10:28 AM at the hospital. The BM and aunt did not provide a reasonable explanation for the death.

Report Determination: Indicated | **Date of Determination:** 09/18/2020

Basis for Determination:
The allegation of IG was added and substantiated against the mother and aunt regarding the child. The child was underweight and required drinking Pediasure. The child had a diaper rash from sitting in a soiled diaper for long periods. The allegation of IG regarding the DS were substantiated as the mother co-slept with the DS, which may have played a role in the death. The aunt was substantiated for IG as the child was not appropriately gaining weight and had a diaper rash. DOA/Fatality was unsubstantiated against the mother and aunt as there was no credible evidence the DS died solely because of co-sleeping and there were no signs of asphyxia.

OCFS Review Results:
The investigation was initiated timely, and the source was called. A CPS history check was completed timely. Written notice of the report nor notice of indication letters were provided to all adults. Safety Assessments were completed inaccurately. Not all household members were interviewed. The SC was in the custody of the aunt; however, the mother also resided in the home.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/20/2020	Sibling, Male, 4 Months	Mother, Female, 19 Years	DOA / Fatality	Unsubstantiated	Yes
	Sibling, Male, 4 Months	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged on 7/20/20, the 4-month-old DS was sleeping in bed with the mother. The mother checked on the DS at 6:00 AM and he was moving and responsive. The mother went back to sleep and later woke to find the DS unresponsive. The aunt was home and called the police. The DS was transported to the hospital and pronounced deceased at 10:23 AM. The mother did not have an explanation for the DS's death.

Report Determination: Indicated | **Date of Determination:** 09/18/2020

Basis for Determination:
The allegation of IG was substantiated as the mother co-slept with the DS. The allegation of DOA/Fatality was unsubstantiated as the investigation did not reveal evidence the mother was responsible for the DS's death. The medical examiner noted the DS did not die of asphyxia nor was there any trauma to the DS's body.

OCFS Review Results:
The investigation was initiated timely, and the source of the report was contacted. A CPS history check was completed timely. The mother and aunt were interviewed, and the home was assessed. Collateral contacts were made. The father of the sibling was not contacted. The adults were not provided with written Notice of Existence or with Notice of Indication letters. The child (SC) was removed from the aunt's care and placed in Foster Care.

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

Issue:
Failure to Conduct a Face-to-Face Interview (Subject/Family)

Summary:
The record did not reflect attempts to contact the father of the deceased sibling.

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

Issue:
Failure to provide notice of report
Summary:
The record did not reflect written notice of the SCR report was provided to the adults.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Issue:
Failure to Provide Notice of Indication
Summary:
The record did not reflect written Notice of Indication was provided to the adults.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
Within seven days of the determination, in such form as required by OCFS, when reports are indicated, ACS must deliver or mail the subject(s) and other persons named in the report, except children under the age of 18, a written notice of indication letter.

Issue:
A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:
The 24-hour Fatality Report was completed 1 day late on 7/22/20.
Legal Reference:
CPS Program Manual, Chapter 6, K-1
Action:
ACS must document and approve a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.

Issue:
The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:
The 30-day Fatality Report was completed untimely on 9/17/20.
Legal Reference:
CPS Program Manual, Chapter 6, K-2
Action:

ACS must document and approve a 30-day Fatality Report within 30 days of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.

[redacted]

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

5/28/18- 7/20/18 The BM was substantiated for PD/AM regarding the SC.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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: 06/04/2018

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?	☐	☒	☐	☐

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?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

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:	Failure to Complete a Plan Amendment
Summary:	At the time this report was written, a Plan Amendment had not been launched nor completed to reflect the death of the child.
Legal Reference:	18 NYCRR 428.7
Action:	ACS will complete a plan amendment when significant change occurs in the status of the case, including a death. This must be done within 30 days of the change if an initial FASP was completed unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time. If a CPS case is open, a plan amendment will be completed within 7 days of the change.
Issue:	Timeliness of completion of FASP
Summary:	A FASP was due to be completed by 12/31/18; however, was not completed until 2/12/19. A FASP was due to be completed by 6/30/19 and was completed on 8/26/19.
Legal Reference:	18 NYCRR428.3(f)
Action:	ACS will complete, or see to the completion of FASPs by service providers when applicable, in a timely fashion when ACS maintains a case management role.
Issue:	Certification or Approval of Foster Family Homes

Summary:	There were 3 foster CHN placed in the home; however, the home was only licensed for 2 CHN. There was no documentation to reflect that ACS took measures to change the foster home certification to accommodate the ongoing placement of 3 CHN.
Legal Reference:	18 NYCRR 443.3
Action:	ACS will follow all foster family boarding home requirements regarding health and safety standards, and physical plant requirements in which the foster home is certified and/or licensed for applicable per regulations.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Within the last 3 years, progress notes were not entered contemporaneously as 101 out of 425 notes were entered more than 30 days after their event dates. Some progress notes were entered more than 11 months after their event dates.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Preventive Services History

10/27/20-10/30/20 While the child was in Foster Care, a Preventive Services Case, listed as an Out of Town Inquiry, was opened to inform the mother the child needed play therapy, dental treatment, and appointments with medical specialists. The child needed Early Intervention services to ensure she was meeting milestones. The mother required parenting classes. The mother did not engage with her service providers and the case was closed.

Foster Care at the Time of the Fatality

The deceased child(ren) were in foster care at the time of the fatality? Yes
Date deceased child(ren) was placed in care: 09/23/2019
Date of placement with most recent caregiver? 04/16/2021
How did the child(ren) enter placement? Court Order

Review of Foster Care When Child was in Foster Care at the time of the Fatality

	Yes	No	N/A	Unable to Determine
Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?	☒	☐	☐	☐
Did the placement comply with the appropriateness of placement standards?	☐	☒	☐	☐
Was the most recent placement stable?	☒	☐	☐	☐
Did the agency comply with sibling placement standards?	☐	☐	☒	☐
Was the child AWOL at the time of death?	☐	☒	☐	☐

Visitation

	Yes	No	N/A	Unable to Determine
Was the visitation plan appropriate for the child?	☒	☐	☐	☐
Was visitation facilitated in accordance with the regulations?	☒	☐	☐	☐
Was there supervision of visits as required?	☒	☐	☐	☐

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?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource made with required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource in the parent/relative/discharge resource's home made with required frequency?	☒	☐	☐	☐
Were all of the casework contact requirements for contacts with the caretakers made, including requirements for contact at the child's placement location?	☒	☐	☐	☐

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the agency provide the foster parents with required information regarding the child's health, handicaps, and behavioral issues?	☒	☐	☐	☐
Did the provider comply with discipline standards?	☒	☐	☐	☐
Were the foster parents receiving enhanced levels of foster care payments because of child need?	☒	☐	☐	☐
If yes, was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	☒	☐	☐	☐
Was the certification/approval for the placement current?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:** 01/15/2020	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 12/20/2019	☒	☐	☐	☐
Was a check completed through the Staff Exclusion List? **Date:** 12/30/2019	☒	☐	☐	☐
Additional information, if necessary: N/A				

Foster Care Placement History

On 7/10/18, ACS filed an Article 10 Neglect Petition against the mother as she was misusing substances. The mother was court-ordered to participate in Services with ACS. The record is unclear as to when the aunt initially obtained custody of the child, but noted the child resided with the aunt and mother. The record reflected on 11/6/19, the child was in the care of the aunt. On 7/22/20, the child was placed in the care of the foster mother as the aunt allowed the mother to violate her court-order because she allowed the mother to be unsupervised around the child. On 10/1/20, the child was moved to the home of a family resource; however, on 4/16/21, the child was moved back to the Foster Care home she resided in at the time of her death. The record was unclear as to why the family resource was no longer an appropriate placement for the child.

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