Child Fatality Report

Report Identification Number: NY-22-066

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

Issue Date: Jan 23, 2023

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

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

☒ The death of a child for whom child protective services 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	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 08/25/2022
Initial Date OCFS Notified: 08/25/2022

Presenting Information

On 8/14/22, between 4:00PM and 5:00PM, the father fed the subject child and laid the child down for a nap on her side. The father placed pillows around her and slept next to her on the bed. The father woke up four hours later to feed the child. The child was on her stomach and unresponsive. The father performed CPR and called EMS. EMS continued CPR and transported the child to the hospital. Life saving measures were performed and there was a return of spontaneous circulation. On 8/15/22, the child was placed on a ventilator and transferred to another hospital. An EEG showed little brain activity and brain death exams were performed 8/19/22, 8/24/22, and 8/25/22. The child was pronounced dead at 2:48PM on 8/25/22. It was believed the unsafe sleep situation contributed to the death. The role of the mother was unknown.

Executive Summary

This report concerns the death of the 2-month-old subject child. The Administration for Children's Services (ACS) received an SCR report regarding the child's death on 8/25/22. At the time of the child's death, she resided in a shelter with her father. The child's mother was inpatient at a substance abuse treatment program. A maternal half-sibling was in foster care and had no contact with the subject child prior to her death. The subject child was listed on an open CPS services case at the time of her death.

On 8/14/22, the father had fed and burped the child and placed her on his bed. The father placed the child's blanket on the bed, propped 2-3 pillows around her to prevent her from rolling, and placed the child down to nap on her back. The father left the child and went to watch television and clean the home. Approximately 1-2 hours later, the father noticed the child had rolled over and went to check on her. The father found the child unresponsive and laying on her stomach, with her head turned so that her cheek was against the mattress. When the father found the child, her face was not obstructed by a blanket or pillows. Immediately upon noticing she was not breathing, the father began CPR and called 911. The father met EMS in the shelter lobby and EMS took over CPR and intubated the child. The child was transported to the hospital via ambulance. Life saving measures were continued and after 8 minutes and 57 seconds there was a return of spontaneous circulation. The child was placed on a ventilator and transferred to a second hospital on 8/15/22. An EEG was performed to determine brain function and there was little activity. Brain death exams were performed on 8/19/22, 8/24/22, and 8/25/22, at which point the child was pronounced dead at 2:48PM.

The medical examiner performed an autopsy. The medical examiner reported the cause of death would most likely be undetermined, as there were multiple factors that may have led to the child's death, including that the child was born testing positive for illegal substances. The final autopsy report remained pending when the investigation was closed. Law enforcement was awaiting the final report from the medical examiner. No arrests had been made prior to the case closing.

ACS interviewed the father and assessed the half-sibling in her foster care setting. Attempts to engage the mother were unsuccessful and she was not provided the Notice of Indication.

ACS substantiated the allegation of Inadequate Guardianship against the father as he failed to provide a minimum degree of care in that he did not adhere to safe sleep practice. The allegation of DOA/Fatality was unsubstantiated as the medical examiner reported being unable to determine the cause of death and there were many factors that may have led to the death.

The parents were offered bereavement services and burial assistance and declined.

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

Explain:
The half-sibling remained in foster care following the fatality investigation closing and the Family Services Stage case remained open. There were no remaining children in the mother or father's household.

Required Actions Related to the Fatality

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

Issue:	Failure to Provide Notice of Indication
Summary:	The case record did not contain documentation that the mother was provided the Notice of Indication, or that attempts were made to provide the notice.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	Within 60 days, whether a report assigned to the investigative track is “indicated” or “unfounded,” and if “indicated," ACS must deliver or mail to the subject(s) and other persons named in the report,

	except children under the age of 18 years, a written notification, within 7 days of the determination, in such form as required by OCFS.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/25/2022 **Time of Death:** 02:48 PM

Date of fatal incident, if different than date of death: 08/14/2022
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: Unknown
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

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	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	53 Year(s)
Other Household 1	Mother	No Role	Female	33 Year(s)

LDSS Response

ACS initiated their investigation within 24 hours. LE chose not to respond with ACS. ACS contacted the source of the report, completed a CPS history check, and notified the DA of the fatality. The half-sibling, who had no contact with SC or SC's household, was in foster care at the time of the fatality and her safety was assessed in the foster home.

SF was asked for a timeline of the events leading up to finding SC unresponsive on 8/14/22. SF said he was on a video call with BM. SC had a 6oz bottle and SF burped SC. SC was still fussy, so SF checked her diaper and laid her on his bed. SF placed SC’s blanket on the bed, propped 2-3 pillows around SC as protection to keep her from rolling over, and placed SC

down on her back. ACS learned from collateral contacts that SF reported he placed SC to sleep on her side, not back. SC fell asleep after being placed down. SF went to watch TV, and then he began to clean and ended the video call with BM. SF said 1-2 hours elapsed before SF noticed SC had rolled over. SF checked on SC, and she was unresponsive. SC was on her stomach and her head was turned with her cheek on the bed. SF denied her face was covered with a sheet or pillow when he found her. When SF noticed SC was not breathing, SF started CPR and called 911. ACS learned SF had CPR training from the hospital when SC was born. SF said it felt like EMS was not responding timely, so he brought SC to the shelter lobby for additional assistance. Shelter staff called 911 as well, and EMS met SF in the lobby. EMS intubated SC and continued CPR until arrival at the hospital. SC was admitted to the hospital at 8:40PM and received multiple doses of epinephrine, calcium chloride, and Narcan. SC was resuscitated, placed on a ventilator, and transferred to another hospital at 2:00AM on 8/15/22. An EEG was completed to determine brain activity. There was little brain activity found and SC had a poor prognosis. Brain tests were repeated 8/19/22, 8/24/22, and 8/25/22. SC was declared brain dead, and SC's death was pronounced at 2:48PM on 8/25/22. SF denied he fell asleep with SC the day of the fatal incident; however, SF did regularly co-sleep with SC. SF voiced he was aware of safe sleep recommendations, and ACS observed a pack and play with safe sleep pamphlets taped to the wall next to the pack and play in the home.

ACS learned the mother was inpatient for substance abuse treatment at the time of the fatal event. ACS attempted to interview the mother at the hospital; however, she did not want to speak with ACS. Upon leaving the hospital, her whereabouts were unknown, and ACS was unable to locate her prior to closing the case.

ACS interviewed the shelter staff member present for the incident. The staff reported SF came down to the lobby, sweating and mumbling, and appeared high. The staff reported SF and BM were known to use drugs and that SF was actively misusing substances. SF completed a drug screen for ACS, which was negative for all substances. ACS interviewed additional shelter staff who worked directly with the family. Concerns were mentioned regarding BM's substance misuse; however, there were no concerns regarding SF misusing substances. ACS confirmed with shelter staff that safe sleep practices were reviewed with residents.

ACS spoke with the ME, who reported the cause of death would most likely be undetermined. The ME reported SC being born with a positive toxicology could be a cause of death. It was discussed with the ME whether a 2-month-old could roll over; however, no conclusion on its possibility was reached.

ACS contacted numerous collateral sources, including hospital staff, shelter staff, LE, ME, and agency staff. Bereavement services and burial assistance were offered to the family. ACS substantiated the allegation of IG against SF and unsubstantiated the allegation of DOA/Fatality.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: The New York City area does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062252 - Deceased Child, Female, 2 Mons	062253 - Father, Male, 53 Year(s)	DOA / Fatality	Unsubstantiated
062252 - Deceased Child, Female, 2 Mons	062253 - Father, Male, 53 Year(s)	Inadequate Guardianship	Substantiated

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:

ACS attempted to interview the BM immediately following the death; however, she declined and then her whereabouts became unknown to ACS.

Fatality Safety Assessment Activities

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

siblings/ other children in the household within 24 hours?				
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The RAP was not scored accurately to reflect the mother's state of housing, the parents' demonstration of appropriate expectations of all children, and the mother having previous termination of parental rights. Although not completed accurately, the final risk rating was "very high" and appropriate services were offered through the ongoing foster care case. At the time this report was written, the mother was not engaged in services.

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
Prior to, and for reasons unrelated to the fatality, the half-sibling was removed and placed in foster care on 12/7/20. She remained in foster care when the fatality investigation was closed.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

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:
SC's half-sibling remained in foster care following the fatality. The mother was provided ongoing case management services through the open case; however, was not actively engaged in services.

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? No
Explain:
There were no other children residing in the home. SC had a half-sibling (age 2), who had no contact with SC or SC's household. No service need in response to the fatality was identified for the half-sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother and father were provided with resources for bereavement services. The father indicated he did not want to

engage in services and the mother ceased communication with ACS following the child's death. Attempts made to locate her were unsuccessful.

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? No
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

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☒ Used illicit drugs
- ☐ Used prescription drugs
- ☐ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☒ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☐ With neither of the issues listed noted in case record

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)
06/23/2022	Deceased Child, Female, 1 Days	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes

Report Summary:
The mother gave birth to SC on 6/22/22. The mother tested positive for cocaine, opiates, cannabis, and methadone at the time of delivery. The mother had a history of heroin use and was in methadone treatment. SC's toxicology report was pending. SC was in the Neonatal Intensive Care Unit being monitored. The mother had additional children outside of her care. SC's father had an unknown role.

Report Determination: Indicated **Date of Determination:** 08/10/2022

Basis for Determination:
ACS substantiated the allegation against the mother. The mother failed to provide a minimum standard of care for SC. The mother tested positive for cocaine, opiates, cannabis, and methadone at the time of delivery. The mother admitted to misusing substances since the age of 19 and that she was was unable to easily stop using drugs. The mother admitted to using cocaine and heroin throughout her pregnancy. SC tested positive for cocaine, opiates, and methadone and had experienced withdrawal symptoms. As a result, SC required extended observation in the Neonatal Intensive Care Unit.

OCFS Review Results:

ACS initiated their investigation within 24 hours, contacted the source of the report, interviewed the parents, and contacted numerous collaterals. Family Court was accessed, and a temporary order of protection was obtained on behalf of SC, which limited BM's contact to supervised. Service needs were identified, and the case was transitioned to the open family services stage for ongoing monitoring. The record did not reflect a Plan of Safe Care was completed, the RAP was scored incorrectly, and the father was not provided the Notice of Indication.

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

Issue:
Failure to Provide Notice of Indication
Summary:
The record did not reflect the father was provided with a Notice of Indication.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
If a report is “indicated”, ACS must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within 7 days of the determination, in such form as required by OCFS.

Issue:
Failure to complete, document, and monitor a Plan of Safe Care
Summary:
ACS failed to develop, document & monitor a Plan of Safe Care to address the health and substance use disorder treatment needs of both the infant and affected caregiver despite knowledge the infant was identified as being born exposed to substances.
Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06
Action:
ACS will complete, document & monitor a Plan of Safe Care that specifically addresses the child(ren) affected by substance misuse and the affected caregiver. LDSS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The RAP was scored incorrectly in that it did not reflect the elevated risk element of prior termination of parental rights.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/10/2020	Sibling, Female, 2 Days	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 2 Days	Mother, Female, 32 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
BM gave birth to the half-sibling on 11/8/20. At the time of delivery, the half-sibling tested positive for cocaine and methadone. She was born at 34 weeks and was showing signs of withdrawal. The half-sibling was last scored at 6:00AM

on 11/10/20 and was sneezing, had tremors, and regurgitated. The mother admitted to cocaine and heroin use on 11/6/20 and methadone 24 hours before delivery. The mother left the hospital on 11/9/20 against medical advice and had not returned. There was no appropriate plan of care for the half-sibling.

Report Determination: Indicated | **Date of Determination:** 12/11/2020

Basis for Determination:
Throughout the investigation, ACS found that the mother did not show or demonstrate an intention to provide adequate guardianship to the half-sibling. The mother used substances to the point the half-sibling was born with a positive toxicology.

OCFS Review Results:
ACS initiated their investigation within 24 hours, contacted the source of the report, and interviewed the subject. ACS maintained collateral contact with hospital staff to monitor the half-sibling's medical status. Family court intervention was sought, and the half-sibling was placed in foster care. The mother's contact with ACS was sporadic. The mother expressed intent to place the child for adoption and provided contact information to ACS. The private adoption agency was not contacted. A Plan of Safe Care was not documented to have been completed, the RAP was scored incorrectly, and the record did not contain documentation that the mother received a Notice of Indication.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP did not reflect that there were MH concerns or that the BM was diagnosed with a mental illness; however, BM indicated she felt depressed and had prior diagnoses of depression and anxiety. Additionally, elevated risk factors existed in that the mother had prior termination of parental rights which were not reflected in the RAP.

Legal Reference:
18 NYCRR 432.2(d)

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

Issue:
Failure to Provide Notice of Indication

Summary:
The record did not reflect the mother was provided with a Notice of Indication.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
If a report is "indicated", ACS must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within 7 days of the determination, in such form as required by OCFS.

Issue:
Failure to complete, document, and monitor a Plan of Safe Care

Summary:
ACS failed to develop, document & monitor a Plan of Safe Care to address the health and substance use disorder treatment needs of both the infant and affected caregiver despite knowledge the infant was identified as being born exposed to substances.

Legal Reference:
17-OCFS-LCM-03 & 18-OCFS-LCM-06

Action:

ACS will complete, document & monitor a Plan of Safe Care that specifically addresses the child(ren) affected by substance misuse and the affected caregiver. ACS will complete the required form (OCFS-2196 Plan of Safe Care), when developing and documenting the Plan of Safe Care with the family.

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
The closing Safety Assessment indicated no safety factors present; however, the half-sibling was in foster care at the time the Safety Assessment was completed, therefore, safety factors were present and the safety decision should have reflected continued placement as a controlling intervention.

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.

[redacted]

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

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

Known CPS History Outside of NYS

There was no known history outside of 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: 11/12/2020

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?				

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:	Timeliness of completion of FASP
Summary:	A plan amendment was not completed following the fatality. The purpose of a plan amendment is to describe/document significant changes in the status of a case and direct a reassessment so that any necessary revisions to the service plan can be made.
Legal Reference:	18 NYCRR428.3(f)
Action:	The Agency will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Preventive Services History

A Family Services Stage (FSS) was originally opened on 11/12/20 due to the half-sibling being born with a positive toxicology, the mother admitting to misusing illegal substances, and the mother failing to make an appropriate plan for the half-sibling following her birth. Service needs identified were parent service needs, parent unavailability, child service needs, and court-ordered placement. The half-sibling was placed into foster care 12/7/20 and remained in foster care at the time of the fatality. The subject child was born during the open CPS services case and was added to the FSS on 7/18/22, with a protective program choice and a permanency planning goal to prevent placement. An Article 10 Neglect petition was filed in family court on 7/1/22 against the mother, on behalf of the subject child. The subject child remained in the custody of the subject father. A plan amendment was completed to reflect the addition of the subject child to the case; however, a plan amendment was not completed when the subject child died. The FSS remained open following the fatality due to the foster care case.

Foster Care Placement History

The half-sibling was placed in foster care on 12/7/20, following an Article 10 Neglect petition against the mother. A neglect adjudication was made on 6/7/21. A contract agency had case planning responsibilities. Throughout the placement, the permanency planning goal remained "return to parent." The record did not reflect the mother had any contact with the half-sibling since her placement on 12/7/20. The record did not contain documentation of conversations with the mother regarding permanency timeframes, or the option of surrender. From placement through June 2022, the case planning agency made efforts to locate and engage the mother in service planning; however, following the birth of SC, the case planning agency missed the opportunity to engage with the mother when ACS located her. No further attempts were documented to reflect efforts to communicate with the mother. Permanency progress issues were recorded incorrectly in the most recent FASP. The half-sibling's father was legally recognized by the court on 6/30/22. The case planning agency was diligent in offering the father regular visitation. At the time of the fatality, the half-sibling remained in foster care and was visiting regularly with her father. Required foster home contacts were completed.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒ Family Court ☐ Criminal Court ☒ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/01/2022	There was not a fact finding	There was not a disposition
Respondent:	062254 Mother Female 33 Year(s)	
Comments:	A neglect petition was filed against the mother on behalf of the SC on 7/1/22, based on derivative neglect and that the mother used cocaine, opiates, and methadone throughout her pregnancy and SC was subsequently born with a positive toxicology. The petition was withdrawn on 8/31/22, due to the death of the SC. All orders in relation to the petition were vacated.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/13/2020	Adjudicated Neglected	Foster Care Placement to Continue
Respondent:	062254 Mother Female 33 Year(s)	
Comments:	A neglect finding was made 6/7/22 through inquest against the mother regarding the half-sibling. The	

	half-sibling was removed 12/7/20, and remained in foster care throughout the fatality investigation.

Have any Orders of Protection been issued? Yes	
From: 07/01/2022	**To:** 08/31/2022
Explain: The mother was ordered to have only supervised contact with the subject child. The order was vacated 8/31/22, following the subject child's death.	

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