# Child Fatality Report

## Report Identification Number: NY-23-009

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

## Issue Date: Jun 29, 2023

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

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

☒ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.

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

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

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

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

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

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

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

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

## Abbreviations

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

## Case Information

**Report Type:** Child Deceased

**Jurisdiction:** Office Of Special Investigations

**Date of Death:** 03/07/2022

**Age:** 3 year(s)

**Gender:** Female

**Initial Date OCFS Notified:** 01/18/2023

### Presenting Information

An SCR report received on 1/18/23 alleged on 3/7/22, the 3-year-old child was found unresponsive by the foster mother and the foster father. The child's cause of death was determined to be acute amphetamine intoxication. The child was not taking any medication at the time of her death and there was no explanation as to why the child had amphetamines in her system. At the time of her death, the child was in the care of the foster parents.

### Executive Summary

This fatality report concerns the death of the 3-year-old SC that occurred on 3/7/22. Immediately following the death, an SCR report was made alleging that the SC was found unresponsive at the foster home. The FM 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 Administration for Children's Services (ACS) concluded their initial investigation after the ME reported the death looked "very much like a seizure"; but could not say with certainty that the SC died of a seizure as the final autopsy report remained pending.

On 1/18/23, ACS received a report from the SCR alleging that the SC's cause of death was determined to be acute amphetamine intoxication. The SC was not prescribed medication and there was no explanation for the amphetamines found in her system. At the time of her death, the SC was in the care of the foster parents, with whom she resided. The SC also resided with the foster parents' children, aged 2 months, 5, and 12 years, and other foster children, aged 3 and 5 years. During the initial investigation, the children were assessed to be safe; however, the foster children were transferred to another foster home due to the death. A sibling resided with a relative and had not met the SC. During the investigation that began on 1/18/23, it was learned that the 5yo foster child resided with a relative and was assessed as safe.

ACS documented the autopsy report listed "the final diagnosis was (I) acute amphetamine intoxication, (II) minor superficial blunt impact injuries of the head with contusion of the head and subscapular hemorrhages of frontal, perinatal and occipital scalp and (III) minor superficial blunt impact injuries of torso with contusion and subcutaneous soft tissue hemorrhage, scant and (IV) minor superficial blunt impact injuries of lower extremities (abrasions and contusions)." The manner of death was not noted in the case record. The record reflected there were no criminal charges.

During the investigation that began on 1/18/23, the foster parents were not forthcoming with information and reported they had retained an attorney due to ACS' prior involvement. The foster parents' children were observed; however, the parents declined for them to be interviewed.

The allegations of Inadequate Guardianship and Poison/Noxious Substances were substantiated against the foster parents as ACS noted that an autopsy yielded the previously mentioned diagnoses. The allegation of DOA/Fatality was unsubstantiated, and ACS noted the death was not caused by the foster parents. It remained unknown if ACS accurately determined DOA/Fatality as the record did not reflect a conversation with the ME or other medical professional regarding the autopsy's findings.

Safety Assessments were inaccurate as they reflected case circumstances at the time of death, including the SC not being adequately supervised in a bathtub. This was an allegation addressed in the previously reported fatality investigation. The 7-day and 30-day Safety Assessment requirements were not met. The 24-hour and 30-day fatality reports were completed in the initial investigation; therefore, unable to be completed when the fatality was again reported to the SCR. The Risk

Assessment Profile was completed inaccurately as it was contradictory to ACS's allegation determination by reflecting the death of a child was the result of abuse or maltreatment. Furthermore, the record did not reflect attempts to contact the parents of the SC or the 5yo foster child.

**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?** No
  - **Safety assessment due at the time of determination?** No
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

**Determination:**

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

**Explain:**
It remained unknown if ACS appropriately determined the allegations as OCFS was not provided with the autopsy report, nor did the record include information from medical professionals regarding the autopsy report. Additionally, ACS did not add and substantiate the allegation of Lack of Supervision, despite noting the foster parents inadequately supervised the SC when she ingested a medication.

| | |
|---|---|
| **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:**
The investigation was inadequate overall. ACS did not document the Safety Assessments timely nor were they or the RAP accurate. Lack of Supervision was not added to the case. There were no documented attempts to contact all parents. All casework requirements were not met. The case was closed as the family did not require further intervention with ACS.

## Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Failure to produce records upon OCFS request |
| **Summary:** | Although requested on numerous occasions, ACS failed to provide OCFS with the autopsy report. |
| **Legal Reference:** | 18 NYCRR 428.10 (a) |
| **Action:** | Records, whether maintained by a district or provider agency pursuant to a purchase of service agreement, must be available at all reasonable times for inspection by representatives of OCFS, and photostatic copies of such records must be forwarded to OCFS upon request. |
| | |
| **Issue:** | Overall Completeness and Adequacy of Investigations |
| **Summary:** | The investigation was inadequate as the Safety Assessments were inaccurate and untimely. The RAP was inaccurate. Attempts to contact the parents of all CHN were not noted. Relevant collaterals were not contacted. Required reports were not completed. |
| **Legal Reference:** | SSL 424.6 and 18 NYCRR 432.2(b)(3) |
| **Action:** | ACS will review and adhere to regulations regarding casework practice in general. ACS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved. |
| | |

# 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 and/or ingested alcohol or drugs?** Yes
**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 | 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 1/18/23, ACS received a fatality report from the SCR. The death occurred on 3/7/22 and had been previously investigated. Within the first 24 hours of the investigation that began on 1/18/23, ACS documented a CPS history check, contacted the source, and notified the district attorney's office of the death.

Law enforcement reported no criminal charges would be filed as the medical examiner's exam did not reveal criminality.

On 1/18/23, a home visit was made. The foster mother declined for her children to be interviewed, yet they were observed to appear clean and safe. The foster mother denied ACS access to the home. The foster mother said according to the medical examiner, the death was due to a seizure. The foster father agreed with the foster mother and did not provide additional information. The foster parents retained an attorney due to the initial investigation and were not willing to participate with the investigation.

On 1/19/23, ACS received a call from the attorney of the foster parents. The attorney stated ACS will not obtain access to the home unless entry was court-ordered.

Case conferences held on 1/19/23 noted that during the initial investigation of the death, ACS viewed a video which showed the child in a bathtub convulsing. In the video, the foster mother was heard telling the child to get up and to use the toilet. The record also reflected the 5-year-old foster child, who lived with the foster family at the time of the death, was prescribed medications. The progress note reflected the hypothesis that the foster child may not have been appropriately supervised while taking his medications. The record stated the 3 and 5-year-old foster children were transferred to a separate foster home following the death. In that home, the 3-year-old foster child ingested and overdosed on medications that were similar to the medication the 5-year-old foster child was prescribed. This concern was noted to have been investigated in another case. The record reflected ACS believed there was a "direct correlation" between the child's overdose and the overdose of the 3-year-old foster child as they both shared foster care placements with the 5-year-old child.

On 2/1/23, the 5-year-old foster child was assessed via a virtual call. The foster child resided with his adult sister. The foster child denied sharing his medication with anyone.

On 3/9/23, ACS spoke to the foster mother at home. The foster mother said the 5-year-old foster child who resided with them at the time of death was responsible with his medications. She stated she would give the foster child his medication and he would walk away and take it. However, went on to say she found a pill on the floor and said that it must have fallen out of his mouth.

The case record reflected that due to the autopsy revealing the child had medication in her system that was not prescribed to her, there was a fair preponderance of evidence to substantiate the case against the foster parents; however, the record also reflected the allegation of DOA/Fatality was unsubstantiated against the foster parents as the investigation revealed "the fatality was not caused by" the foster parents. Additionally, the record reflected the foster parents stated they did not know how the child had access to the medication, leading to questions regarding the supervision of the child in the home. However, an allegation of Lack of Supervision was not added to the case.

## Official Manner and Cause of Death

**Official Manner:** Unknown
**Primary Cause of Death:** From an injury - external cause
**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
**Comments:** New York City does not have a OCFS-approved Child Fatality Review Team.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 063896 - Deceased Child, Female, 3 Yrs | 063898 - Foster Parent, Female, 31 Year(s) | DOA / Fatality | Unsubstantiated |
| 063896 - Deceased Child, Female, 3 Yrs | 063898 - Foster Parent, Female, 31 Year(s) | Inadequate Guardianship | Substantiated |
| 063896 - Deceased Child, Female, 3 Yrs | 063898 - Foster Parent, Female, 31 Year(s) | Poisoning / Noxious Substances | Substantiated |
| 063896 - Deceased Child, Female, 3 Yrs | 063899 - Foster Parent, Male, 39 Year(s) | DOA / Fatality | Unsubstantiated |
| 063896 - Deceased Child, Female, 3 Yrs | 063899 - Foster Parent, Male, 39 Year(s) | Inadequate Guardianship | Substantiated |
| 063896 - Deceased Child, Female, 3 Yrs | 063899 - Foster Parent, Male, 39 Year(s) | Poisoning / Noxious Substances | 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?** | ☐ | ☒ | ☐ | ☐ |
| Medical Examiner / Coroner | ☐ | ☒ | ☐ | ☐ |
| **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:**
The foster parents did not allow their children to be interviewed.

## 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?** | ☐ | ☐ | ☒ | ☐ |

**Explain:**
Although diligent attempts were made to assess the safety of the foster parents' children, ACS was unable to interview them as the foster parents were non-compliant with the investigation. The children were observed to be free of any visible marks or bruises. The 5-year-old foster child was assessed to be safe in the care of a relative.

## 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 foster parents and their children as well as the mother were offered bereavement services in the initial investigation regarding the death. | | | | |

## Placement Activities in Response to the Fatality Investigation

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?** | ☐ | ☒ | ☐ | ☐ |
| **Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?** | ☐ | ☒ | ☐ | ☐ |
| **Explain as necessary:** The surviving foster 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** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**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:**
Immediately following the death, 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:**
Immediately following the death, the mother and the foster parents 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 acutely ill during the two weeks before death?** No

## CPS - Investigative History Three Years Prior to the Fatality

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 03/07/2022 | Deceased Child, Female, 3 Years | Foster Parent, Female, 31 Years | DOA / Fatality | Unsubstantiated | Yes |
| | Deceased Child, Female, 3 Years | Foster Parent, Female, 31 Years | Inadequate Guardianship | Substantiated | |
| | Deceased Child, Female, 3 Years | Foster Parent, Male, 39 Years | DOA / Fatality | Unsubstantiated | |
| | Deceased Child, Female, 3 Years | Foster Parent, Male, 39 Years | Inadequate Guardianship | Substantiated | |
| | Deceased Child, Female, 3 Years | Foster Parent, Female, 31 Years | Burns / Scalding | Unsubstantiated | |

| | | | | |
|---|---|---|---|---|
| | Deceased Child, Female, 3 Years | Foster Parent, Female, 31 Years | Lacerations / Bruises / Welts | Unsubstantiated |

**Report Summary:**
An SCR report alleged on 3/7/22, the 3-year-old SC was at the foster home when she went into cardiac arrest. EMS was called, responded to the home and performed CPR. The SC was transported to the hospital where she was pronounced deceased at approximately 5:45 AM. The SC was otherwise healthy and was in the care of the foster parents at the time of her death. A subsequent report received on the same day alleged the SC had unexplained bruises, including one near her eye. The SC had a 3rd 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. There were no plausible explanations provided for the bruises or marks.

**Report Determination:** Indicated | **Date of Determination:** 05/06/2022

**Basis for Determination:**
The Investigation Conclusion Narrative stated the foster parents failed to appropriately care for the SC and that the SC would have tantrums that progressed to convulsions. Knowing this, the foster mother left the SC unattended in a bathtub for about 20 minutes. The foster father stated the SC was unsupervised for an hour. The SC had a convulsion after putting hand sanitizer in her eyes. There were concerns the SC was oftentimes hungry and unhappy. The SC missed therapy sessions. There was no evidence the SC died as a result of abuse or maltreatment.

**OCFS Review Results:**
The investigation was initiated timely. The Safety Assessments and required reports were completed timely. The Safety Assessments did not accurately reflect case circumstances. The family was interviewed, and parents were contacted.

**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 child'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:**
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 07/21/2020 | Deceased Child, Female, 2 Years | Mother, Female, 19 Years | Inadequate Guardianship | Substantiated | No |
| | Sibling, Male, 4 Months | Mother, Female, 19 Years | Inadequate Guardianship | Substantiated | |
| | Deceased Child, Female, 2 Years | Aunt/Uncle, Female, 40 Years | Inadequate Guardianship | Substantiated | |
| | Sibling, Male, 4 Months | Aunt/Uncle, Female, 40 Years | Inadequate Guardianship | Substantiated | |
| | Deceased Child, Female, 2 Years | Mother, Female, 19 Years | DOA / Fatality | Unsubstantiated | |
| | Deceased Child, Female, 2 Years | 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 Inadequate Guardianship 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 allegations of Inadequate Guardianship regarding the aunt was substantiated 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 or notice of indication letters were not provided to all adults. Safety Assessments were completed inaccurately. Not all household members were interviewed.

**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 sibling was sleeping in bed with the mother. The mother checked on the sibling at 6:00 AM and he was moving and responsive. The mother went back to sleep and later woke to find the child unresponsive. The aunt was home and called the police. The sibling was transported to the hospital and pronounced deceased at 10:23 AM. The mother did not have an explanation for the sibling'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 sibling. The allegation of DOA/Fatality was unsubstantiated as the investigation did not reveal evidence the mother was responsible for the sibling's death. The medical examiner noted the sibling did not die of asphyxia nor was there any trauma to the sibling'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 of the SCR report or with notice of indication letters. The child 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:**
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary.

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

**Summary:**
Although the subject child was removed from the aunt's custody and placed in a non-kinship foster home, ACS did not add allegations against the aunt's reflecting she neglected the subject child by allowing the mother to violate her order of supervision.

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

**Action:**
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary.

**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:**
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary.

**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:**
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary.

**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:**
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary.

[redacted]

05/28/18- 07/20/18 The BM was substantiated for PD/AM of the SC.

**Known CPS History Outside of NYS**

There is no known CPS history outside of New York.

**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?** | ☒ | ☐ | ☐ | ☐ |

**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:** | A Plan Amendment was not completed to reflect the death of the child within the required timeframe. |
| **Legal Reference:** | 18 NYCRR 428.7 |
| **Action:** | There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary. |
| | |
| **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:** | There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary. |
| | |
| **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:** | There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary. |
| | |
| **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:** | There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. NYCRO will continue to work on this issue with ACS and revise their current PIP if deemed necessary. |

**Preventive Services History**

10/27/20-10/30/20 While the child was in Foster Care, a Preventive Services Case was opened to inform the mother the child needed play therapy, dental treatment, and appointments with medical specialists to address her weight. 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:** 07/10/2018
**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:** The child's Foster Care case closed after the fatality. | | | | |

## 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 was unclear as to when the aunt initially obtained custody of the child, but noted the child resided with the aunt and the 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 the 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, 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