Child Fatality Report

Report Identification Number: NY-23-056

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

Issue Date: Oct 17, 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: 06/02/2023

Age: 3 month(s)

Gender: Female

Initial Date OCFS Notified: 06/03/2023

Presenting Information

An SCR report received 6/2/23 alleged, that on the evening of 6/2/23, while the father was visiting with the 3-month-old subject child in the foster home where she resided, the child was found unresponsive. Law enforcement and emergency medical personnel responded to the home and transported the child to the hospital, where she was pronounced deceased at 10:14PM. The child was otherwise healthy, and no explanation had been provided for the death. Two additional reports were received regarding the fatal incident and included allegations that the father had laid the child in bed with him. The father got up to use the restroom, and when he returned, the child was laying on her back, unresponsive. There were blankets, pillows, and clothing on the bed where the child was sleeping and the overall condition of the home was deplorable, with excessive clutter throughout.

Executive Summary

This report concerns the death of the 3-month-old subject child. The Administration for Children's Services (ACS) received multiple SCR reports regarding the child's death. The child was in foster care with a kinship resource at the time of her death.

On 6/2/23, the subject child had a routine doctor's appointment at the foster care agency, which was unremarkable. The foster parent returned home with the child around 1:22PM and found the child's father waiting at the foster home for visitation. The father visited with the child in the backyard, where they had a cookout. Sometime after 5:44PM, it began to rain and the foster parent, child, and father went inside the home. The foster parent fed the child a bottle, burped her, then placed her in a bouncer chair to sleep around 7:30PM. The chair was placed on top of the foster parent's bed, upstairs. The foster parent returned downstairs. Approximately two hours had passed and upon seeing the father going to the restroom, the foster parent asked the father to check on the child. The foster parent was unaware the father had been with the child upstairs during that two-hour window. The father had removed the child from the bouncer chair when the foster parent went downstairs and had laid on the bed with the child on his chest for approximately 45 minutes, until the child had fallen asleep. Once the child was asleep, the father laid the child on her back, on the adult-sized bed, and went to the restroom. When he returned to check on the child about two minutes later, she was blue. The father panicked and called for the foster parent. The foster parent came upstairs, yelled for someone to call 911, and began CPR. Law enforcement was the first to arrive and ultimately transported the child and foster parent to the hospital as an ambulance had not yet responded to the home. The child arrived at the hospital in cardiac arrest. She had no heart rate or pulse. CPR and lifesaving measures were exhausted, and the child was pronounced dead at 10:14PM. The foster parent notified the foster care agency, who in turn notified the mother.

The medical examiner performed an autopsy. The cause and manner of death were pending at the time the CPS investigation closed. The preliminary report indicated the child had an umbilical hernia. There were no congenital anomalies, no obvious signs of infection, and no external injuries noted. ACS spoke with the medical legal investigator who commented the condition of the foster home was very messy and cluttered. It had appeared the child was sleeping on the foster parent's bed. A requested CT scan yielded negative findings for bleeds or fractures and there were no marks or bruises to the child's body. While the diagnosis was cardiac arrest, it was unknown what caused the child to go into cardiac arrest.

ACS interviewed the foster parent and father. The mother was spoken to; however, had not been present at the time of the

fatality and did not have anything additional to add. The foster care agency and ACS case manager monitoring the child's placement were interviewed as well. Bereavement services were offered by ACS and the foster care agency.

ACS determined there were several lapses in care and supervision on the part of the foster parent. Despite being provided a crib and Pack 'n Play by ACS, the foster parent gave away the crib and did not utilize the Pack 'n Play for its intended use when she placed the child to sleep in a bouncer chair. The home was undergoing a renovation and was in disarray at the time of the fatality. Additionally, the foster parent had agreed to follow the visitation plan devised by the foster care agency, which stipulated the parents were to be supervised with the child. Despite this, the father was left without proper supervision.

It was recommended the foster home be closed.

PIP Requirement
ACS and the cited agency 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:**
  - **Safety assessment due at the time of determination?** 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? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
A familial and companion foster care report were received and the investigations ran concurrently. There were no surviving siblings and no other children placed in the foster home at the time of the child's death. While the investigations into the fatality were determined and closed, the services case remained open due to the minor mother's service needs.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/02/2023 **Time of Death:** 10:14 PM

Time of fatal incident, if different than time of death: 09:50 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 09:52 PM
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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 Month(s)
Deceased Child's Household	Foster Parent	Alleged Perpetrator	Female	46 Year(s)
Deceased Child's Household	Other Adult - Foster Parent's Adult Child	No Role	Male	22 Year(s)
Deceased Child's Household	Other Adult - Foster Parent's Adult Child	No Role	Female	30 Year(s)
Other Household 1	Mother	No Role	Female	16 Year(s)
Other Household 2	Father	Alleged Perpetrator	Male	22 Year(s)

LDSS Response

ACS initiated their investigation within 24 hours. LE had responded to the fatality prior to ACS involvement. The sources of the SCR reports were contacted, CPS history checks were completed, and the DA was notified.

ACS interviewed the foster parent, father, and foster parent's adult children who were present during the fatal event. ACS learned on the day of the fatality the child had a 12:00PM routine medical appointment at the foster care agency. Collateral contact revealed there were no reported concerns, and the child was a well child. The father had arrived at the foster home for visitation and waited at the home until the foster parent and child returned at 1:22PM. They went to the backyard for a cookout. Once it started raining, they went inside, and the foster parent fed the child a bottle between 6-7:00PM. About

7:30PM, the foster parent brought the child upstairs to the foster parent's bedroom and placed the child into a bouncer chair, which was placed on top of the foster parent's bed. The foster parent returned downstairs to the living room. The father reported he went upstairs and took the child out of the bouncer chair and laid on the bed, with the child on his chest. The father recalled the child burped and spit up on him. He held the child this way for about 45 minutes until the child fell asleep. Once the child was asleep, he placed her on her back, on the bed, and went to use the restroom. The father returned about two minutes later and found the child blue in color. The father denied having fallen asleep with the child at any point. He called to the foster parent, who came upstairs and began CPR. The foster parent's adult child had just arrived at the home when this occurred and heard his mother call for someone to call 911, so he did. The 911 call was registered at 9:52PM. LE responded to the home, and upon noticing an ambulance had not yet arrived, at 9:56PM LE transported the child and foster parent to the hospital, where the child was pronounced deceased.

ACS learned the foster parent had been identified as a resource by the parents. The child was placed with the resource on 3/20/23, over ACS's initial recommendation that the proposed resource be a placement option for the mother only. ACS completed an expedited home study, and no safety concerns were noted for the home at that time. A foster home visit prior to the fatality was completed on 5/26/23 and the home was being renovated. The living room was noted to have items lined against the wall, with clear passageways; the dining room had clothing and other items and boxes lined against the wall as well, and the kitchen was clean and free of clutter. The child slept in a Pack 'n Play which was appropriate at the time it was observed. A foster home visit on 6/3/23 described the home to be in deplorable condition. The home was dirty and cluttered, with piles of clothing everywhere, paint peeling off walls, broken items, and the Pack 'n Play was full of items. The foster parent reported the home was in this state due to a renovation that had been started 3-4 days prior. ACS confirmed both a crib and a Pack 'n Play had been provided to the foster parent. The foster parent gave away the crib and stated she cleared the Pack 'n Play every night. She denied ever placing the child on her bed to sleep. The foster parent expressed understanding of the parents' visitation plan but when asked if she supervised the parents, she responded, "not all the time, most of the time." The foster care agency denied knowing the foster parent was not adhering to the visitation plan. The foster parent was in the process of becoming certified and as she had not yet completed certification, no other children had been placed in her home.

Services were offered to the parents and foster parent. The foster care agency helped with burial costs. Due to the mother's foster care placement, the family services stage remained open, and services continued to be offered to the mother.

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 region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064690 - Deceased Child, Female, 3 Mons	064752 - Father, Male, 22 Year(s)	DOA / Fatality	Unsubstantiated

064690 - Deceased Child, Female, 3 Mons	064752 - Father, Male, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
064690 - Deceased Child, Female, 3 Mons	064748 - Foster Parent, Female, 46 Year(s)	DOA / Fatality	Unsubstantiated
064690 - Deceased Child, Female, 3 Mons	064748 - Foster Parent, Female, 46 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
064690 - Deceased Child, Female, 3 Mons	064748 - Foster Parent, Female, 46 Year(s)	Inadequate Guardianship	Substantiated
064690 - Deceased Child, Female, 3 Mons	064748 - Foster Parent, Female, 46 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐
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:
The mother was interviewed over the telephone, not face-to-face.

Fatality Safety Assessment Activities

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

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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

The mother and father were provided with bereavement resources. It was unknown if the father engaged in services prior to the CPS investigation closing. The mother's services case remained open and services continued to be offered to the mother, who was seeking mental health services in response to the fatality. The foster parent was provided resources and had begun engaging in bereavement services.

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

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 none 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)
03/02/2023	Deceased Child, Female, 4 Days	Mother, Female, 16 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Deceased Child, Female, 4 Days	Mother, Female, 16 Years	Inadequate Guardianship	Substantiated	

Report Summary:
The SCR report alleged the mother, a minor, gave birth to the subject child. Prior to giving birth, the mother was homeless due to a history of running away and she refused to return to her mother's home. The mother was voluntarily placed with ACS; however, runaway from the facility and was homeless until she delivered the child. As a result of the mother's homelessness, the child suffered complications of low birth weight. The mother had untreated mental health concerns and was prescribed medication which she ceased taking during the pregnancy. The mother lacked housing, had no supplies for the child, and was unable to provide the level of care and supervision the child needed.

Report Determination: Indicated | **Date of Determination:** 05/01/2023

Basis for Determination:
The allegations against the mother were substantiated. The mother had been voluntarily placed in foster care and was awaiting placement in a specialize mother/child program; however, due to her runaway behaviors, the mother jeopardized her placement status and was unable to maintain stable placement. Her whereabouts were unknown while absent from placement and she missed prenatal appointments and the child was born underweight. Additionally, the mother had untreated mental health concerns. Overall, ACS concluded the mother failed to prepare and plan for the birth of the child and was unable to provide adequate provisions for the child upon her birth.

OCFS Review Results:
ACS initiated their investigation timely. The subject child was removed from the mother's care and placed pursuant to FCA 1017 with the MGM, then moved to the home of the subject foster parent at the mother and father's request. Although the father was having supervised visits and referred to participate in parenting class, the record did not reflect any family court proceedings against the father. The record did not reflect the Notice of Indication was sent. Due to the service needs identified and the subject child's placement status, the family continued to be monitored by ACS in a previously opened services case.

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

Issue:

Failure to Provide Notice of Indication

Summary:

The investigation was indicated; however, the record did not reflect the Notice of Indication was provided to the mother or father.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/18/2021	Other - Foster Parent's Child, Male, 18 Years	Foster Parent, Female, 44 Years	Childs Drug / Alcohol Use	Unsubstantiated	No
	Other - Foster Parent's Child, Male, 18 Years	Foster Parent, Female, 44 Years	Inadequate Guardianship	Unsubstantiated	
	Other - Foster Parent's Child, Male, 18 Years	Foster Parent, Female, 44 Years	Sex Trafficking	Unsubstantiated	
	Other - Foster Parent's Child, Male, 18 Years	Other - Foster Parent's Child, Male, 19 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Other - Foster Parent's Child, Male, 18 Years	Other - Foster Parent's Child, Male, 19 Years	Inadequate Guardianship	Unsubstantiated	
	Other - Foster Parent's Child, Male, 18 Years	Other - Foster Parent's Child, Male, 19 Years	Sex Trafficking	Unsubstantiated	

Report Summary:

The SCR report alleged the foster parent, and her adult children were selling the foster parent’s 17-year-old child for sex to unknown people. The foster parent and her adult children were selling drugs and the foster parent was allowing the alleged 17-year-old to use drugs and sell drugs as well. It was unknown if the child had ever been injured.

Report Determination: Unfounded | **Date of Determination:** 03/17/2021

Basis for Determination:

ACS unsubstantiated all allegations. At the time of the investigation, the alleged maltreated child was 18 years old and therefore not a minor child. Through coordination with law enforcement and other agency personnel, it was determined there was nothing to support the allegations in the report. As there were no minor children residing in the home, the investigation was unfounded and closed.

OCFS Review Results:

Upon initial contact it was learned there were no minor children residing in the home. ACS confirmed the alleged 17-year-old was in fact 18 years old. All adults in the home denied the allegations. ACS coordinated with collaterals, which did not yield evidence to support the allegations.

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)
01/18/2021	Other Child - Unknown Child,	Foster Parent, Female,	Inadequate	Unsubstantiated	No

	Unknown, 5 Years	44 Years	Guardianship	

Report Summary:
An SCR report alleged that the foster parent was a daycare provider and was selling drugs and participating in other criminal activity out of the home while providing daycare services to multiple unknown children. It was unknown if the children were ever injured. The roles of the children's parents were unknown.

Report Determination: Unfounded | **Date of Determination:** 03/16/2021

Basis for Determination:
The allegations against the foster parent were unsubstantiated. The investigation confirmed that no daycare was being operated from the foster parent's home and that no minor children were in the home. Coordination with the caseworker assigned the concurrent familial report supported the findings. Police reports requested did not yield any criminal activity.

OCFS Review Results:
This investigation ran concurrently to an open investigation; however, was coded Day Care as the foster parent had been alleged to be providing childcare services and was investigated by the Office of Special Investigations (OSI). The NYC Department of Health and Mental Hygiene investigated as well, as the regulating body for day care centers in the NYC area. The status of their investigation was unknown when the OSI investigation closed. It was learned the foster parent ran a dance studio, not a daycare, which was closed due to the COVID-19 pandemic and operated off-site.

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)
09/04/2020	Other Child - Unrelated child, Female, 4 Months	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Unrelated child, Male, 2 Years	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Inadequate Guardianship	Substantiated	
	Other Child - Unrelated child, Male, 1 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Unrelated child, Male, 1 Years	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Unrelated child, Male, 1 Years	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Inadequate Guardianship	Substantiated	
	Other Child - Unrelated child, Male, 1 Years	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Lack of Supervision	Substantiated	
	Other Child - Unrelated child, Male, 1 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unrelated child, Male, 1 Years	Foster Parent, Female, 43 Years	Lack of Supervision	Unsubstantiated	
	Other Child - Unrelated child, Male, 2 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unrelated child, Female, 4 Months	Foster Parent, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged that the foster parent and an unrelated other adult sold drugs out of the home, in the presence of four children, who were also not subjects of this fatality report. The report alleged a 2-year-old child was missing meals on a regular basis and was hungry, and the adults failed to address this. On 9/2/20, the foster parent and other adult left the 2-year-old unsupervised for an unknown amount of time, and as a result, the child walked into the road and was

almost struck by a vehicle.

Report Determination: Indicated | **Date of Determination:** 10/29/2020

Basis for Determination:
ACS substantiated the allegations against the other adult, as it was determined the 1-year-old, not 2-year-old, was able to leave the home and had been found outside by a neighbor after an unknown length of time. Additionally, the 2-year-old was not adequately supervised by the other adult, who was charged with caring for the child at the time. Allegations against the foster parent were unsubstantiated as the foster parent was unaware the other adult was watching the children in her home. It was learned the 4-month-old was with her mother at the time of the incident, therefore, allegations pertaining to her were unsubstantiated.

OCFS Review Results:
This report was received during an open CPS investigation concerning the same household composition; however, was not consolidated. The record did not reflect as part of this investigation attempts to contact the other adult, who was a subject of the SCR report. Not all allegations enumerated in the report were addressed. The subject children of this report did not reside with the foster parent or other adult and were assessed safe with their mother in a separate household.

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

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

Summary:
The allegation of drugs being sold out of the home and the child missing meals was not addressed with either alleged subject. The record did not reflect attempts were made to speak to the other adult named as an alleged subject.

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

Action:
ACS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/02/2020	Other Child - Unrelated child, Female, 4 Months	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Unrelated child, Male, 2 Years	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Inadequate Guardianship	Substantiated	
	Other Child - Unrelated child, Male, 1 Years	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Unrelated child, Male, 1 Years	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Inadequate Guardianship	Substantiated	
	Other Child - Unrelated child, Male, 1 Years	Other Adult - Foster Parent's Child's Friend, Male, 19 Years	Lack of Supervision	Substantiated	
	Other Child - Unrelated child, Male, 1 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Unrelated child, Male, 1 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unrelated child, Male, 1 Years	Foster Parent, Female, 43 Years	Lack of Supervision	Unsubstantiated	
	Other Child - Unrelated child, Male, 2 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Unsubstantiated	

	Other Child - Unrelated child, Female, 4 Months	Foster Parent, Female, 43 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
The SCR report alleged that on 9/2/20, the foster parent and unrelated other adult failed to adequately supervise a 2-year-old child, also not part of this fatality report. As a result, the child left the residence for an unknown amount of time, but prior to 12:30PM. The child did not sustain injuries.

Report Determination: Indicated | **Date of Determination:** 10/29/2020

Basis for Determination:
ACS unsubstantiated the allegations against the foster parent as they determined she was unaware of the children being in the home. Allegations against the other adult were substantiated as ACS concluded the 1 and 2-year-old children were not adequately supervised, and as a result, the 1-year-old was found outside the home by a neighbor after an unknown amount of time.

OCFS Review Results:
ACS initiated their investigation timely and learned the mother of the children had asked her friend, the unrelated other adult, to babysit the 1 and 2-year-old children. The other adult had the children at the foster parent's home, as he was friends with the foster parent's 17-year-old son. ACS learned the foster parent was unaware the children were in her home. The mother of the children made alternative childcare plans. ACS assisted with a daycare voucher and Pack 'n Plays for two children to ensure each child had a separate and safe sleeping space. Only one attempt to contact the source of the report was documented and there were limited relevant collateral contacts.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
One attempt to contact the source was made on 9/2/20 and there were missed opportunities to gather collateral information from law enforcement who responded to the incident and the neighbor who found the child.

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

Action:
ACS will contact, or make diligent efforts to contact, the source of all SCR reports to verify adequacy of report and possibly glean additional information and will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

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

The foster parent had unsubstantiated history with ACS dating back to 2013.

In March 2006, a Court Ordered Investigation was initiated and subsequently withdrawn, regarding a change in custody status of one of the foster parent's now adult children.
In December 2013, allegations of Inadequate Guardianship and Lack of Supervision were unsubstantiated.
In April and December of 2015, allegations of Educational Neglect, Inadequate Food/Clothing/Shelter, and Inadequate Guardianship were unsubstantiated.
In January 2019, allegations of Inadequate Food/Clothing/Shelter and Inadequate Guardianship were unsubstantiated.
In July 2020, allegations of Child's Drug/Alcohol Use, Inadequate Food/Clothing/Shelter, Inadequate Guardianship, and Parent's Drug/Alcohol Misuse were unsubstantiated.

Known CPS History Outside of NYS

There was 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: 09/02/2021

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?	☐	☐	☒	☐

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: 03/20/2023
Date of placement with most recent caregiver? 03/20/2023
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:**	☐	☒	☐	☐
Was a check completed through the State Central Register? **Date:**	☐	☐	☐	☒
Was a check completed through the Staff Exclusion List? **Date:**	☐	☐	☐	☒

Additional information, if necessary:
Although the record reflected checks through the SCR and Staff Exclusion List were completed, there were no dates provided. The foster parent had completed Mini-MAPP training and was scheduled for additional training in June 2023. The home study had not yet been completed prior to the fatality.

Required Action(s)

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

Issue:	Failure to Complete a Plan Amendment
Summary:	A plan amendment was not completed following the fatality. As there was no FASP due within 60 days of the death, it should have been recorded in a plan amendment.

Legal Reference:	18 NYCRR 428.7
Action:	The agency with case planning responsibility will complete a plan amendment any time a significant change occurs in the status of the case, including 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.
Issue:	Adequacy of Medical care of child
Summary:	Medical appointments were reported to have occurred on 3/11/23, 3/27/23, April 2023, 5/1/23, and 6/2/23; however, records were not obtained or content documented in progress notes or the health tab section of CONNECTIONS.
Legal Reference:	18 NYCRR 441.22
Action:	Each foster child must have complete periodic individualized medical examinations, the results of which must be maintained in the child's uniform case record.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	7 of the 22 progress notes entered for events that occurred since the agency's assignment in CONNECTIONS and up until the child's death were recorded over 30 days since the event date. 13 of those 22 notes were entered after the date of death.
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.

Foster Care Placement History

The mother was in foster care at the time of the subject child's birth; however, was absent from placement. Upon learning of the child's birth, a child safety conference was held on 3/2/23 and a remand of the child was recommended. The child was in the hospital at that time and upon her discharge on 3/9/23, she was placed pursuant to FCA 1017 with the maternal grandmother. On 3/20/23, the placement was changed in family court at the request of the child's parents and the child was placed into foster care and into the home of the subject foster parent. The foster parent had a prior positive relationship with the parents and the child was placed into her home on an emergency basis while the kinship certification was underway. Although ACS assessed the home prior to the child's placement, the foster home certification had not yet been completed prior to the child's death. The record reflected ACS and the foster care agency were aware of the renovations going on in the home. It was noted at the last foster home visit prior to the death (5/26/23), the home did not appear to be in the state of disarray it was observed to be in on the date of the death. The subject child was removed from the family services stage following her death and the case remained open due to the mother's foster care status with a permanency planning goal of placement in another planned living arrangement.

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

Child Fatality Report

Date Filed:	Fact Finding Description:	Disposition Description:
03/09/2023	There was not a fact finding	There was not a disposition
Respondent:	064751 Mother Female 16 Year(s)	
Comments:	ACS filed a neglect petition against the mother on behalf of the subject child, citing the mother's mental health concerns, history of non-compliance with services, lack of prenatal care, and pattern of runaway behavior. The child was removed and placed pursuant to FCA 1017 with the maternal grandmother, on 3/9/23. On 3/20/23, the placement was changed to foster care at the request of the child's parents. The child was placed with the subject foster parent on that date. The family services stage record reflected the petition against the mother was withdrawn following the child's death. The father remained a non-respondent to family court proceedings throughout the case.	

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