Child Fatality Report

Report Identification Number: NY-23-088

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

Issue Date: Mar 12, 2024

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: 09/20/2023

Age: 1 year(s)

Gender: Female

Initial Date OCFS Notified: 09/15/2023

Presenting Information

The SCR report alleged on 9/15/23, the subject child became unresponsive at home while in the care of the mother and father. The father called 911 and emergency medical services responded to the home where they performed cardiopulmonary resuscitation on the subject child and transported her to the hospital. The subject child had a bilateral skull fracture, a brain bleed, and a laceration on her forehead. The subject child was intubated and placed on life support. The parents provided no explanation for how the subject child sustained the injuries. On 9/20/23, the subject child had testing on her brain activity and it was determined at 3:51PM that the subject child was brain dead and her brain was no longer receiving oxygen. A duplicate report noted the subject child died from blunt force trauma to the head.

Executive Summary

This fatality report concerns the death of the 1-year-old female subject child. An initial report regarding the fatal incident was received on 9/15/23 with allegations of Inadequate Guardianship, Fractures, Lacerations/Bruises/Welts, and Swelling/Dislocation/Sprains against the mother and father. A subsequent report was received regarding the fatality on 9/22/23 with allegations of DOA/Fatality, Internal Injuries, Inadequate Guardianship, and Lacerations/Bruises/Welts against the mother and father. There was an open foster care case at the time of the subject child's death due to a previous Neglect finding from August of 2022, in which the subject child suffered multiple non-accidental fractures while in the care of the parents. At the time of her death, the subject child and the 2-year-old surviving sibling had been residing with the mother and father on a trial discharge that was granted on 6/16/23.

The Administration for Children's Services (ACS) completed casework and collateral contacts to obtain information regarding the circumstances surrounding the subject child's death and learned that on 9/15/23, the subject child became unresponsive. The father reported he was feeding the subject child when she choked on milk and was gasping. The mother was reportedly out of the home at the time of the incident and when she returned the father stated something was wrong with the subject child. The mother contacted emergency medical services who responded to the home, attempted life-saving measures, and transported the subject child to the hospital. The subject child was transported to a different hospital as it was discovered she had sustained multiple injuries and required a higher level of care. The subject child was noted to have severe injuries to the head and body including multiple fractures to the skull, a fracture to the jaw, bleeding to the brain, bruising to the forehead, two bite marks on her thigh, lacerations and hematomas to the head, swelling of the eyelid, and retinal hemorrhages. Medical staff reported these injuries were non-accidental as there was no plausible accidental explanation for the subject child's injuries and the injuries were consistent with abusive head trauma. Multiple brain activity tests were conducted, and it was determined the subject child was brain dead. The subject child succumbed to her injuries on 9/20/23.

An autopsy was completed, and the final cause and manner of death were pending; however, the medical examiner provided a preliminary cause of death as blunt force trauma of the head and the manner was homicide. The criminal investigation was ongoing at the time this report was written and no arrests had been made related to the subject child's death.

Bereavement services were offered to the family. The trial discharge ended on 9/18/23 and the sibling was placed with the maternal grandmother, whose care the children had been in prior to the trial discharge. Services on behalf of the sibling

were being implemented and monitored through the foster care case which remained open. An Abuse Petition was filed on behalf of the sibling and an Order of Protection was put in place prohibiting contact between the parents and sibling. The allegations were substantiated against the mother and father, as the subject child's injuries were determined to be non-accidental in nature, and the CPS case was indicated and closed on 11/20/23.

PIP Requirement

ACS and the contract 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:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:

ACS made an appropriate determination based on evidence obtained throughout their investigation.

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:

Casework activity was commensurate with case circumstances.

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: 09/20/2023 **Time of Death:** 03:51 PM

Date of fatal incident, if different than date of death: 09/15/2023
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: 06:43 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Other Household 1	Foster Parent	No Role	Female	60 Year(s)

LDSS Response

Upon receipt of the initial SCR report, ACS began gathering information related to the circumstances surrounding the fatal incident. ACS coordinated their investigation with LE and the DA's office, contacted collateral sources, completed a CPS history check, attempted interviews with the parents, and assessed the safety of the SS.

ACS attempted to interview the SM and SF regarding the allegations; however, they were not cooperative. The SF did state that he had been feeding the SC a bottle when she started gasping but would not provide additional details and stated he would not speak without his legal counsel. ACS attempted to engage the SM and she refused to speak with ACS. ACS learned from collateral sources that the SM reported she left the home on 9/15/23 for approximately 30 minutes to sell her phone to get money for food, as the family did not have any. At the time the SM reportedly left the home, the SF and the

children were asleep. When the SM returned, the SF had the SC on his shoulder and was tapping her back but nothing alarming was happening. The SM then reported leaving again to go to the mailbox and when she returned the SF stated the SC was not responding and choked on milk. The SM called 911 and went outside to locate LE and EMS. The SC was transported to the hospital and the SM rode with her. The SC remained intubated and hospitalized until 9/20/23 when she was pronounced brain dead.

The children were previously removed from the parents on 8/16/22 after a DV incident in which the children were medically examined as a result and it was discovered the SC had multiple non-accidental fractures. The children were originally placed with the PGM; however, were removed from the PGM's home after the PGM left the SF unsupervised with the SC and the SC sustained a laceration to the tongue that required her to be hospitalized for multiple days. The children were placed with the MGM and remained in her care until the trial discharge on 6/16/23. Following the trial discharge, the parents became uncooperative with the contract agency, were not attending all necessary medical appointments for the children, and were not participating in services previously ordered by the court. The court was updated on the parents' non-compliance at a subsequent hearing on 9/14/23 where it was ordered the trial discharge continue and all orders remain in place.

A foster care visit by the contract agency, which included their agency nurse, was conducted on 9/13/23 and there were no concerns noted during that home visit for the safety or well-being of the children.

Following the fatal incident, the sibling returned to the care of the MGM. The foster care case remained open, and the Abuse Petition proceedings were ongoing in family court. The parents were not allowed contact with the sibling due to an OP being in place.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066410 - Deceased Child, Female, 1 Year(s)	066411 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
066410 - Deceased Child, Female, 1 Year(s)	066411 - Mother, Female, 29 Year(s)	Fractures	Substantiated
066410 - Deceased Child, Female, 1 Year(s)	066411 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
066410 - Deceased Child, Female, 1 Year(s)	066411 - Mother, Female, 29 Year(s)	Internal Injuries	Substantiated
066410 - Deceased Child, Female, 1	066411 - Mother, Female, 29	Lacerations / Bruises /	Substantiated

Year(s)	Year(s)	Welts	
066410 - Deceased Child, Female, 1 Year(s)	066412 - Father, Male, 29 Year(s)	DOA / Fatality	Substantiated
066410 - Deceased Child, Female, 1 Year(s)	066412 - Father, Male, 29 Year(s)	Fractures	Substantiated
066410 - Deceased Child, Female, 1 Year(s)	066412 - Father, Male, 29 Year(s)	Inadequate Guardianship	Substantiated
066410 - Deceased Child, Female, 1 Year(s)	066412 - Father, Male, 29 Year(s)	Internal Injuries	Substantiated
066410 - Deceased Child, Female, 1 Year(s)	066412 - Father, Male, 29 Year(s)	Lacerations / Bruises / Welts	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?	☒	☐	☐	☐
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 was unable to conduct a home visit due to the parents' home being deemed a crime scene. The parents refused to speak with ACS and obtained legal counsel.

Fatality Safety Assessment Activities

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

At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☒	☐	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: The trial discharge ended on 9/18/23 and the SS returned to the care of the MGM.				

Legal Activity Related to the Fatality

Was there legal activity as a result of 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:
09/28/2023	There was not a fact finding	There was not a disposition
Respondent:	066411 Mother Female 29 Year(s)	
Comments:	An Abuse Petition was filed on 9/28/23 against the parents on behalf of the surviving sibling, due to the subject child's non-accidental injuries and subsequent death.	

Have any Orders of Protection been issued? Yes	
From: 09/28/2023	**To:** Unknown
Explain: An Order of Protection was requested and granted on behalf of the surviving sibling at the time the Abuse Petition was filed on 9/28/23. The Order of Protection prohibited any contact or visitation between the parents and sibling.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☒	☐	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☒	☐	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The record reflected that ACS offered bereavement services and that necessary services would be followed up with in the

open foster care case. Burial assistance was provided by the contract agency at the directive of ACS. An Early Intervention referral was completed for the SS; however, the parents' were refusing to consent to 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? Yes
Explain:
Services were being provided to the SS through the foster care case that remained open. The SS was recommended to engage in play therapy.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to the family; however, it was unknown if they were utilized.

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)
09/15/2023	Sibling, Male, 2 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 2 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 29 Years	Fractures	Substantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 29 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 29 Years	Swelling / Dislocations / Sprains	Substantiated	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Fractures	Substantiated	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 1 Years	Father, Male, 29 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Female, 1	Father, Male, 29 Years	Swelling / Dislocations /	Substantiated	

	Years		Sprains	

Report Summary:
The SCR report alleged that the SC was brought to the hospital for cardiac arrest and difficulty breathing. Upon examination, the SC presented with a hematoma, bruises on the face and a skull fracture. The SM stated the SC choked on milk while in the SF's care. The SM's explanation was not consistent with the injuries; therefore, the SM and SF were subjects of the report. The SC was intubated. Two duplicate reports were received regarding the same allegations.

Report Determination: Indicated | **Date of Determination:** 11/14/2023

Basis for Determination:
ACS substantiated the allegations against the SM and SF stating the SM and SF did not take the SC or SS to medical appointments while they were trial discharged. The SC was admitted to the Pediatric Intensive Care Unit and a comprehensive assessment was completed by the hospital on 9/16/23 which revealed a fracture to the jaw, hematomas, bruising to the brain and forehead, skull fractures, lacerations to the chin, bite marks to the thigh, and swelling to the eyelid consistent with an impact injury to the head. There were no accidental explanations for the SC's injuries and the SC succumbed to her injuries on 9/20/23. The SS was present in the home when the SC became unresponsive.

OCFS Review Results:
ACS initiated their investigation within 24 hours by contacting the source of the report, assessing the safety of the SS, and conducting a visit to the hospital where the SC was located. ACS coordinated efforts with their MDT team. ACS was in constant communication with medical staff regarding the SC's status. The SC was listed as a MA child when the allegations were regarding abuse. The record reflected the parents were not cooperative with ACS and obtained legal counsel; however, there were opportunities to speak with the parents documented in which concerns were not addressed including a subsequent report, the SM being under the influence, and a fight that occurred between the parents.

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

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

Summary:
Though the record reflected the parents' obtained counsel, there were documented phone calls with the parents during the investigation. ACS did not attempt to address concerns including a subsequent report, the SM being under the influence after the fatal incident, and a fight between the parents occurring the day before. These concerns were not further explored with collateral sources.

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

Action:
ACS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/10/2022	Deceased Child, Female, 1 Months	Father, Male, 28 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 1 Months	Father, Male, 28 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Female, 1 Months	Father, Male, 28 Years	Fractures	Unsubstantiated	

Report Summary:
The SCR report alleged that the SC presented with a laceration in her mouth while in the SF's care. The SF had no explanation for the SC's injury; therefore, the SF was the subject of the report.

Report Determination: Indicated	**Date of Determination:** 10/07/2022

Basis for Determination:
The allegations of IG and L/B/W against the SF were substantiated. ACS found a fair preponderance of evidence that the SF inserted a tube into the SC's mouth which caused her to have a laceration on her tongue and left the house without notifying anyone that the SC was bleeding. The SC was hospitalized for many days, and she was unable to eat. The allegation of FX against the SF was unsubstantiated as the SC did not have any new fractures.

OCFS Review Results:
ACS initiated their investigation within 24 hours conducting a visit to the hospital to assess the SC and a home visit to the PGM's residence to assess the SS. ACS attempted to interview the parents; however, they refused to engage with ACS. There was no documentation surrounding the SC's discharge from the hospital or follow-up with necessary medical providers regarding ongoing concerns that the SC was underweight. Information regarding services the SF was receiving, casework contacts with the caregivers/children, and information pertinent to the investigation were not documented.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
There was no documentation regarding the details surrounding the SC's discharge from the hospital following the laceration of her tongue. The record did not reflect that ACS followed up with medical collaterals regarding the SC being underweight and the necessary medical care needed for the SC to maintain a healthy weight, despite supervisory directive to do so.

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

Action:
ACS 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.

Issue:
Case record contains information that is relevant, useful, factual and objective

Summary:
ACS maintained an open services case during this investigation. In this instance, maintaining two separate records resulted in fragmented case recording. Information pertinent to the investigation, including services the SF was receiving and casework contacts with the children and their caregivers were not reflected in the investigation.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:
ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/10/2022	Deceased Child, Female, 1 Months	Grandparent, Female, 49 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 1 Months	Grandparent, Female, 49 Years	Lack of Supervision	Substantiated	
	Deceased Child, Female, 1 Months	Father, Male, 28 Years	Fractures	Unsubstantiated	

Deceased Child, Female, 1 Months	Father, Male, 28 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 1 Months	Father, Male, 28 Years	Lacerations / Bruises / Welts	Substantiated

Report Summary:
The SCR report alleged the PGM was aware the SF was not allowed to be unsupervised with the SC due to concerns of unexplained injuries while in the SF's care, including a skull fracture, broken ankles, and a broken collar bone. On 9/10/22, the PGM left the SC unsupervised with the SF for an unknown period of time. As a result, the SC sustained a laceration to her mouth that bled while in the SF's care. The SF left the home and provided no explanation for the SC's injury.

Report Determination: Indicated | **Date of Determination:** 11/09/2022

Basis for Determination:
ACS stated the PGM failed to supervise the SF with the SC and the SF inflicted an injury to the SC by other than accidental means causing a serious injury that was not consistent with the narrative provided during medical assessment. Hospital staff stated the SC sustained a 2-centimeter laceration on her tongue that could develop complications that may impact her ability to chew effectively when she began solid foods, to speak, and potentially to breathe if the deformity of the tongue blocked her airway. The PGM allowed the SF to visit with the SC on an unscheduled date and failed to follow through with a court order. The SC did not sustain any fractures during the reported incident.

OCFS Review Results:
ACS initiated their investigation within 24 hours by contacting the source of the report, assessing the CHN, and contacting collateral sources. Due to ACS maintaining multiple investigations during this time, the case record was fragmented and inconsistent. Pertinent information was not documented, including information regarding the SC's discharge from the hospital and the CHN being replaced with a different relative. The SM was minimally engaged during this investigation and services were not offered to her. An unrelated home member residing in the CHN's foster home was not engaged and there was no record that the relative's 10-month-old child was assessed during visits to the home.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
Pertinent information was not in the investigative case record. There was no documentation surrounding the SC's discharge from the hospital or the CHN's transition into a new foster home with the maternal relative. The SM was minimally engaged in the investigation and services were not explored with her. There was an unrelated home member who was not engaged and a child who was not assessed.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
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.

Issue:
Case record contains information that is relevant, useful, factual and objective

Summary:
ACS maintained 3 investigations and a services case during this time. Maintaining two separate records, in this case, led to fragmented casework and parts of the record being incomprehensible. ACS had two concurrent cases open with the Office of Special Investigations (OSI). These investigations were not consolidated leading to gaps in documentation and inconsistent information being recorded.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:
ACS records must contain information that is relevant, useful, factual, and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/10/2022	Deceased Child, Female, 1 Months	Grandparent, Female, 49 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 1 Months	Grandparent, Female, 49 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The SCR report alleged the PGM left the SC in the SF's care unsupervised, which resulted in the SC being injured. The PGM was aware of the SF's history of physical aggression toward the SC and that the SF was not to be around the SC unsupervised. After the SF left, the PGM found the SC had blood in her mouth and around the area where she was sleeping. The SC had a 2-centimeter laceration on her tongue.

Report Determination: Indicated | **Date of Determination:** 11/09/2022

Basis for Determination:
ACS stated the PGM failed to supervise the SF with the SC and the SF inflicted an injury to the SC by other than accidental means causing a serious injury that was not consistent with the narrative provided during medical assessment. Hospital staff stated the SC sustained a 2-centimeter laceration on her tongue that could develop complications that may impact her ability to chew effectively when she began solid foods, to speak, and potentially to breathe if the deformity of the tongue blocked her airway. The PGM allowed the SF to visit with the SC on an unscheduled date and failed to follow through with a court order.

OCFS Review Results:
ACS initiated their investigation within 24 hours by contacting the source of the report, assessing the CHN, and contacting collateral sources. Pertinent information was not documented, including information regarding the SC's discharge from the hospital and the CHN being replaced with a different relative. The SM was minimally engaged during this investigation and services were not offered to her. An unrelated home member residing in the CHN's foster home was not engaged and there was no record that the relative's 10-month-old child was assessed during visits to the home. The Safety Assessment and Risk Assessment Profile were completed inaccurately.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
Pertinent information was not in the investigative case record. There was no documentation surrounding the SC's discharge from the hospital or the CHN's transition into a new foster home with the maternal relative. The SM was minimally engaged in the investigation and services were not explored with her. There was an unrelated home member who was not engaged and a child who was not assessed.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
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.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:

While the record reflected continuous discussion and follow-up regarding the SC's medical needs, the record did not reflect that ACS followed up with the SC and SS's pediatrician regarding medical concerns related to the SS and to inquire about the outcome of the CHN's well-child visits.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

ACS 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.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The safety decision at the time the investigation closed was inaccurate and did not reflect that the CHN were currently in foster care.

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.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP did not reflect an elevated risk rating despite the RAP from a concurrent investigation reflecting as such. The SC sustained a physical injury as a result of the PGM leaving the SC unsupervised with the SF, which was against a court order. ACS substantiated the allegation of IG against the PGM due to this injury.

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)
08/11/2022	Deceased Child, Female, 21 Days	Mother, Female, 28 Years	Fractures	Substantiated	Yes
	Deceased Child, Female, 21 Days	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 21 Days	Father, Male, 28 Years	Fractures	Substantiated	
	Deceased Child, Female, 21 Days	Father, Male, 28 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Months	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Months	Father, Male, 28 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 11 Months	Mother, Female, 28	Fractures	Unsubstantiated	

		Years			

Report Summary:
The SCR report alleged that on 8/11/22, the SM physically assaulted the SF in the presence of the SC and SS. The SM pushed the SF while he was holding the SS. The CHN did not sustain any injuries during the altercation. Two subsequent reports were received. The first report stated the SS hit his head on the wall when the SM pushed the SF. The second report stated the SC sustained a fracture to both ankles and her clavicle, and the SM and SF were unable to provide an explanation for the injuries.

Report Determination: Indicated | **Date of Determination:** 09/02/2022

Basis for Determination:
The allegations of IG and FX against the SM and SF were substantiated. ACS noted there was a fair preponderance that the parents engaged in a verbal altercation in the presence of the CHN that resulted in the SF picking up the SS and the SM pushing the SF into a wall, causing the SS to bump his head. The CHN were taken to the hospital as a result, and it was determined the SC had multiple fractures as a result of non-accidental trauma. The CHN were removed from the parents' care and placed into foster care. The allegation of FX against the SM and SF regarding the SS was unsubstantiated as the SS was medically assessed at the hospital and had no fractures.

OCFS Review Results:
ACS initiated their investigation within 24-hours upon receipt of the SCR report by interviewing the SM and SF at the hospital. ACS learned upon medical examination that the SC had multiple fractures, two of which were deemed to be the result of non-accidental trauma. ACS interviewed the parents regarding the injuries and the CHN were subsequently removed from the parents' care and placed into foster care with the PGM. ACS completed documentation timely. The record noted the SC also had a skull fracture; however, it is unknown where this information was received as the SC's medical documentation did not reflect such injury. The record did not reflect safe sleep was reviewed with the PGM.

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

Issue:
Case record contains information that is relevant, useful, factual and objective

Summary:
The record did not reflect conversations with the PGM regarding being a resource for the CHN, supervision requirements for visitation, or planning surrounding the CHN's safety while in her care.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:
ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Issue:
Failure to provide safe sleep education/information

Summary:
While adequate sleeping provisions were noted, the record did not reflect that safe sleep guidelines were reviewed with the PGM, despite the children being placed into her care after the removal from the SM and SF's care. Both children were under the age of 1 and the PGM was a certified foster parent.

Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:
ACS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Date of	Alleged	Alleged	Allegation(s)	Allegation	Compliance

SCR Report	Victim(s)	Perpetrator(s)		Outcome	Issue(s)
05/25/2022	Sibling, Male, 8 Months	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 8 Months	Mother, Female, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 8 Months	Father, Male, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Months	Father, Male, 27 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The SCR report alleged that the SS appeared to be underweight and had suspicious marks on him while in the care of the SM and SF. Two months prior to the SCR report, the SS had a suspicious red handprint mark on his face. The SM and SF had no explanation for the injuries.

Report Determination: Unfounded **Date of Determination:** 07/22/2022

Basis for Determination:
ACS unsubstantiated the allegations of the report stating there was no evidence to support the concerns. ACS stated it appeared that the SM met the SS's overall needs. ACS observed the SS's provisions, including food, a crib, and clothing, to be adequate. The SM would not sign a release of information and ACS was unable to speak with medical providers pertaining to the concern for the SS being malnourished. ACS did not observe the SS to have any marks or bruises, other than a small scratch the size of a dime on his chest and a distinct birthmark down his back.

OCFS Review Results:
ACS initiated the investigation by contacting the source of the report and attempting to locate the family. Upon locating the family, ACS interviewed the SF and assessed the safety of the SS. The SM was initially uncooperative. ACS was unable to speak with medical collaterals due to the parents' refusal to sign a release of information; however, the SF was willing to obtain medical documentation at the SS's next appointment. ACS closed the investigation before this appointment occurred and without obtaining any medical documentation from the SF. ACS did not provide the SM with DV resources. Services were only offered to the SF, who was the alleged perpetrator of the DV.

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

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

Summary:
The allegations of the report were predetermined. While the parents refused to sign a release of information regarding the SS's medical care, the SF agreed to obtain documentation at the SS's next appointment. When the appointment was rescheduled, ACS closed the investigation without obtaining any medical documentation from the SF. The SM was not re-engaged regarding the report or risk assessment.

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

Action:
ACS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Issue:
Failure to Offer Appropriate Services

Summary:
A DV consultation was completed, which recommended DV services be offered to the SM, despite the denial of current DV. While the SM was uncooperative during the initial visit, the record did not reflect that DV services were offered to the SM. ACS had opportunity to speak privately on the phone with the SM, but DV services were only provided to the

SF, who was the alleged perpetrator of the DV.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, ACS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

[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 CPS history outside of New York State.

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The most recent FASP was submitted timely on 9/14/23 by the contract agency; however, was not approved by ACS until 10/18/23.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

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:
Date of placement with most recent caregiver? 06/16/2023
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:
The children were initially removed from the parents' care on 8/16/22 and placed with the PGM. The children were removed from the PGM's care on 9/16/23 and placed with the MGM until a trial discharge was granted on 6/16/23. The children remained in the care of the parents on a trial discharge until the fatal incident on 9/15/23.

Required Action(s)

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

Issue:	Adequacy of Medical care of child
Summary:	Multiple medical appointments were reported to have occurred with necessary specialists; however, the outcome and content of medical records were not 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:	Adequacy of monitoring child/family while in foster care
Summary:	During the foster care case, face-to-face contacts with the MGM, who was the children's certified foster parent, were not made with the required frequency.
Legal Reference:	18 NYCRR 441.21
Action:	ACS, or the purchase of service agency, shall provide casework contact services to the child, the child's caretakers, and to the child's parents or relatives at least monthly.

Foster Care Placement History

The children were removed from the parents' care on 8/16/22 following a domestic incident between the parents which resulted in the children being medically evaluated and it being determined the SC sustained multiple non-accidental fractures. A Neglect Petition was filed in court. The parents had supervised visitation and the children were placed with the PGM. On 9/10/22, the PGM left the SF unsupervised with the SC and she sustained a severe laceration to the tongue which required her to be hospitalized. Upon her discharge, the children were removed from the PGM's home and placed with the MGM. There was a finding of Neglect on 3/17/23 in which the parents made admissions to causing harm to the SC. The parents had supervised visitation until a trial discharge was granted on 6/16/23. After the trial discharge, the parents became uncooperative with the contract agency, did not attend multiple medical appointments for the children, and were not complying with services previously ordered by the court. The court was updated about the parents' non-compliance at a subsequent hearing on 9/14/23. On 9/15/23, the SC was brought to the hospital in cardiac arrest with multiple non-accidental injuries consistent with abusive head trauma and succumbed to her injuries on 9/20/23. The trial discharge ended on 9/18/23. The SS returned to the MGM and an Abuse Petition was filed.

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:**
08/16/2022	Adjudicated Neglected	Care/Custody to Local Social Services District
Respondent:	066411 Mother Female 29 Year(s)	
Comments:	There was an initial Neglect Petition filed on 8/16/22 against the SM and SF due to a domestic incident that occurred in the presence of the CHN. The SS allegedly hit his head during the incident, resulting in both children being medically evaluated. It was discovered at that time that the SC had two fractures that were determined to be non-accidental trauma. The children were removed and placed with the PGM, until an incident in which the SF was left unsupervised with the SC, and she sustained a laceration to her tongue. The SS and SC were then placed with the MGM until their trial discharge to the SM and SF on 6/16/23. At a subsequent hearing on 9/14/23, the contract agency updated the court that the parents were not complying with previously mandated court orders regarding maintaining the children's necessary medical appointments, engagement in services for themselves and the children, and the parents' hesitancy to cooperate with the contract agency/ACS. The judge ordered all current orders to remain in place and the trial discharge to continue.	

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