Child Fatality Report

Report Identification Number: SY-23-023

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

Issue Date: Oct 03, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 04/25/2023
Initial Date OCFS Notified: 04/25/2023

Presenting Information

Oneida County Department of Social Services (OCDSS) received an SCR report that alleged at an unknown time on 4/25/2023, the daycare provider fed the subject child a bottle and some pureed fruit and vegetable and then placed him in a crib for a nap. At an unknown time later, the daycare provider checked on the subject child and found him on his side unresponsive and not breathing. 911 was contacted and the daycare provider began to perform cardiopulmonary resuscitation on the subject child. Law enforcement and emergency medical services arrived and continued life-saving measures. The subject child was transported to the hospital and was pronounced deceased. The subject child was an otherwise healthy child and there was no explanation for his death. The biological mother had no role.

Executive Summary

This fatality report concerns the death of a 5-month-old male subject child that occurred on 4/25/2023. The SCR report contained allegations of Inadequate Guardianship, DOA/Fatality and Inadequate Food/Clothing/Shelter against the daycare provider. At the time of his death, the subject child was in foster care and resided with his foster parents and three foster siblings. The subject child had maternal half-siblings that he had never met and were not in the custody of the birth mother. The biological father of the subject child was unknown.

OCDSS collaborated investigative efforts with law enforcement and learned that on 4/25/2023 the daycare provider was caring for the subject child along with eleven children in her home. There were two other adults, a 21-year-old and a 29-year-old, helping the daycare provider care for the children including the subject child on that day. The daycare provider's spouse who would usually help care for the children was out of town at the time of the incident. On the morning of 4/25/2023, the daycare provider left the residence at approximately 8:00AM to drop off school-aged children at their school and stop at a medical office. The daycare provider returned to the home at approximately 10:00AM. During the time the daycare provider was gone the 29-year-old other adult was caring for the subject child. That adult spoon-fed the subject child some pureed baby food at 7:30AM and approximately 5 ounces of a formula bottle at 9:00AM and then laid the child in a crib on his back for a nap at 10:00AM. Approximately 30 minutes later, the 29-year-old adult went to check on the subject child and found him unresponsive. The subject child was brought to the living room area and cardiopulmonary resuscitation was started by the 29-year-old adult and the 21-year-old adult while the daycare provider called 911. Emergency medical services and law enforcement arrived and took over life-saving measures. The subject child was transported to the hospital via ambulance where life-saving measures continued; however, were unsuccessful. The subject child was pronounced deceased at 11:28AM.

An autopsy was performed, and the cause of death was listed as unexplained sudden death of an infant and the manner of death was listed as undetermined. The medical examiner revealed no injuries, no congenital anomaly, and no acute disease process to account for the death but a nasopharynx swab was positive for rhinovirus. Law enforcement did conduct a criminal investigation; however, the record did not reflect an update on the details of the investigation and the update received was approximately four months after the subject child's death.

OCDSS had not determined the allegations of Inadequate Guardianship, Fatality/DOA and Inadequate Food/Clothing/Shelter against the daycare provider and the CPS investigation remained open and pending at the time this report was written.

OCDSS offered bereavement services to the daycare provider, other adults in that home, the subject child's foster parents,

foster siblings, and the birth mother. Burial assistance was offered and accepted by the birth mother.

PIP Requirement
OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) that OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
Casework was not commensurate with case circumstances. OCDSS did not interview or address the report with the biological parents of the foster siblings that were present in the DCP's home when the SC became unresponsive. Safe sleep education was not provided to the FP's or the DCP.

Was the decision to close the case appropriate?	N/A
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:
There was detailed documentation in the case record of supervisory consult and the case remained open at the time this report was written.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	The record did not reflect attempts were made to interview the biological parents of the 8-month-old and 4-year-old foster siblings who were present at the daycare during the incident regarding the CPS report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	OCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or

	guardians and document efforts that were unsuccessful.
Issue:	Case Record includes written consideration of safety and appropriateness of placement
Summary:	Eight foster children resided in the home of the daycare provider where their minimal care needs were not being met due to over-crowding, health and safety concerns, and an illegal daycare being run out of the same home.
Legal Reference:	18 NYCRR 430.11(c)(2)(vii)
Action:	OCDSS will demonstrate district compliance with OCFS's standards for family and children's services when making decisions regarding the placement of children in foster care.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Multiple progress notes had added addendums more than 90 days from the event date.
Legal Reference:	18 NYCRR 428.5
Action:	OCDSS will enter progress note as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.
Issue:	Failure to provide safe sleep education/information
Summary:	The daycare provider (DCP) and foster parents were caring for or providing daycare services to a child under the age of 1-year-old; however, the record did not reflect for several months after the death that safe sleep education was provided despite both providers were still caring for foster children of all ages. The record contained photos of the subject child's crib and they did not reflect safe sleep was being practiced at the DCP's home. The subject child's foster parents were not educated on safe sleep upon the SC being placed in their care until the day before his death which was approximately 5 months after being placed in foster care.
Legal Reference:	13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1
Action:	OCDSS 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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/25/2023 **Time of Death:** 11:28 AM

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? Yes
Time of Call: 10:46 AM
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	Male	5 Month(s)
Deceased Child's Household	Foster Parent	No Role	Female	42 Year(s)
Deceased Child's Household	Foster Parent	No Role	Male	41 Year(s)
Deceased Child's Household	Other Child - foster sibling	No Role	Female	8 Month(s)
Deceased Child's Household	Other Child - foster sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Other Child - foster sibling	No Role	Male	4 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	43 Year(s)
Other Household 1	Other - Daycare Provider's spouse	No Role	Male	47 Year(s)
Other Household 1	Other - Daycare provider's child	No Role	Female	13 Year(s)
Other Household 1	Other - Daycare provider's child	No Role	Male	9 Year(s)
Other Household 1	Other - Daycare provider's child	No Role	Male	17 Year(s)

LDSS Response

Upon receipt of the SCR report on 4/25/2023, OCDSS initiated their response in coordination with law enforcement. OCDSS interviewed collateral sources, home members, the foster home certifying agency and did a CPS history check regarding the daycare provider (DCP) and BM. The district attorney's office was notified, and the autopsy was requested from the ME. There were multiple home visits conducted of the DCP and the SC's foster parents' home. The maternal half-siblings were assessed to be safe with their respective caregivers. The DCP's children were assessed to be safe due to their age; however, the DCP's foster children were placed in respite and later removed from the DCP's home due to health and safety concerns.

OCDSS interviewed the DCP at her home and learned that the DCP was also a FP and had eight foster children residing in the foster home. On 4/25/2023 at approximately 8:00AM the DCP took five of the foster children to school while two foster children who were not yet school-age remained at the home with the 21yo adult (OA1) and 29yo adult (OA2). One foster child was on a trial discharge with her BF. Four other daycare children were also at the home during the time of the incident, all of which were not yet school age. The OA2 spoon-fed the SC a small amount of pureed baby food between approximately 7:30AM and 8:00AM. The OA2 then brought the SC upstairs to play in an exersaucer before feeding him a five-ounce bottle at 9:00AM. At approximately 10:00AM the OA2 placed the SC in a crib on his back for a nap. The DCP returned home at approximately the same time, 10:00AM; however, did not witness the OA2 place the SC down for a nap. Approximately 30-45 minutes later the OA2 was placing two other children down for naps when a noise was heard from the SC's crib. The OA2 checked on the SC who was face-down on his stomach. The OA2 turned the SC over and observed his face to be red with white around his lips and he was unresponsive. The OA2 quickly picked up the SC and brought him downstairs into the living room where the OA1 and OA2 started to perform CPR on the SC while the DCP called 911. Law enforcement and EMS arrived and continued life-saving measures. EMS reported that the SC was asystole, and they

were unable to establish an intravenous catheter (IV) or give medications. The SC was transported to the hospital and arrived with a body temperature of 85 degrees. The SC was pronounced deceased at 11:28AM.

OCDSS did not observe the crib that SC was napping in due to it being taken by law enforcement as evidence. The record reflected the crib did have a small stuffed animal in it when the police observed and confiscated it. The record did not initially reflect that the DCP, OA1 or OA2 were provided with safe sleep guidelines immediately following the death of the subject child. The record did reflect the DCP was aware that the OA2 had developmental and mental health needs that should have excluded them from being a caretaker for the foster and daycare children.

OCDSS learned through medical records and interviews that the SC was born with a positive toxicology to amphetamines and was removed from his BM and placed in foster care upon discharge as a newborn. The SC was documented to have a cough, nasal congestion and poor weight gain on and off from birth until about three weeks prior to his death. The SC was routinely taken to his medical appointments and all recommendations were followed by his FPs.

OCDSS learned the DCP was running an illegal daycare and the Office of Children and Family Services served the DCP with a cease-and-desist order for the daycare. The DCP's eight foster children were removed from her care on a health and safety standard. Multiple safety hazards were documented within the DCP's home. Two additional CPS investigations were reported after the SC died, for the foster children and the DCP's own children, regarding the condition of the home and safety hazards. Those investigations remained open at the time this report was written.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From a medical 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? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064321 - Deceased Child, Male, 5 Month(s)	064335 - Day Care Provider, Female, 43 Year(s)	DOA / Fatality	Pending
064321 - Deceased Child, Male, 5 Month(s)	064335 - Day Care Provider, Female, 43 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐

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

Fatality Safety Assessment Activities

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

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

Explain:
Safety assessments were not required in this fatality due to it being a daycare case; however, OCDSS documented an assessment of the SS safety following the death and there were no concerns.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
OCDSS offered bereavement services to the half-siblings but they were declined by family.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS offered bereavement services to caregivers and the BM but they were declined.

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)
04/27/2023	Other Child - fathers biological child, Male, 9 Years	Mother, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	No
	Other Child - fathers biological child, Male, 9 Years	Mother, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - fathers biological child, Female, 13 Years	Mother, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - fathers biological child, Female, 13 Years	Mother, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - mothers biological child, Male, 17 Years	Mother, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - mothers biological child, Male, 17 Years	Mother, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - fathers biological child, Male, 9 Years	Father, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - fathers biological child, Male, 9 Years	Father, Male, 47 Years	Inadequate Guardianship	Pending	
	Other Child - fathers biological child, Female, 13 Years	Father, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - fathers biological child, Female, 13 Years	Father, Male, 47 Years	Inadequate Guardianship	Pending	
	Other Child - mothers biological child, Male, 17 Years	Father, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - mothers biological child,	Father, Male, 47	Inadequate Guardianship	Pending	

	Male, 17 Years	Years		

Report Summary:
An SCR report alleged that on 4/27/2023 the home of the DCP and the PS was a health and safety hazard for their biological children, 13yo OC, 9yo OC and 17yo OC who resided there. This home was also a certified foster home, and a companion report was registered for the 8 foster children who resided in the home in addition to the biological children.

Report Determination: Undetermined

OCFS Review Results:
This investigation remained open at the time this report was written.

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)
04/27/2023	Other Child - foster child , Male, 2 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	Yes
	Other Child - foster child , Male, 2 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - foster child , Female, 3 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - foster child , Female, 3 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - foster child , Female, 4 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - foster child , Female, 4 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - foster child , Female, 5 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - foster child , Female, 5 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - foster child , Male, 6 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - foster child , Male, 6 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - foster child , Male, 6 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - foster child , Male, 6 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - foster child , Female, 7 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - foster child , Female, 7 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - foster child , Male, 8 Years	Foster Parent, Female, 43 Years	Inadequate Food / Clothing / Shelter	Pending	
	Other Child - foster child , Male, 8 Years	Foster Parent, Female, 43 Years	Inadequate Guardianship	Pending	
	Other Child - foster child ,	Foster Parent, Male, 47	Inadequate Food /	Pending	

Male, 2 Years	Years	Clothing / Shelter	
Other Child - foster child , Male, 2 Years	Foster Parent, Male, 47 Years	Inadequate Guardianship	Pending
Other Child - foster child , Female, 3 Years	Foster Parent, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending
Other Child - foster child , Female, 3 Years	Foster Parent, Male, 47 Years	Inadequate Guardianship	Pending
Other Child - foster child , Female, 4 Years	Foster Parent, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending
Other Child - foster child , Female, 4 Years	Foster Parent, Male, 47 Years	Inadequate Guardianship	Pending
Other Child - foster child , Female, 5 Years	Foster Parent, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending
Other Child - foster child , Female, 5 Years	Foster Parent, Male, 47 Years	Inadequate Guardianship	Pending
Other Child - foster child , Male, 6 Years	Foster Parent, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending
Other Child - foster child , Male, 6 Years	Foster Parent, Male, 47 Years	Inadequate Guardianship	Pending
Other Child - foster child , Male, 6 Years	Foster Parent, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending
Other Child - foster child , Male, 6 Years	Foster Parent, Male, 47 Years	Inadequate Guardianship	Pending
Other Child - foster child , Female, 7 Years	Foster Parent, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending
Other Child - foster child , Female, 7 Years	Foster Parent, Male, 47 Years	Inadequate Guardianship	Pending
Other Child - foster child , Male, 8 Years	Foster Parent, Male, 47 Years	Inadequate Food / Clothing / Shelter	Pending
Other Child - foster child , Male, 8 Years	Foster Parent, Male, 47 Years	Inadequate Guardianship	Pending

Report Summary:
An SCR report alleged that on 4/27/2023 the certified foster home of the DCP and the PS was a health and safety hazard for their 8 foster children, 7yo FC, 4yo FC, 6yo FC, 6yo FC, 5yo FC, 6yo FC, 2yo FC, 2yo FC who resided there.

Report Determination: Undetermined

OCFS Review Results:
This investigation remained open at the time this report was written.

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

Issue:
Appropriateness and adequacy of child's foster care placement

Summary:
The DCP and PS were approved in their FAD certification as Foster Parents to be able to accept 5 children ages 1-month-old to age 21 years old. There were 8 total foster care children placed in the DCP's home. This is over the limit of the number of children certified to board at this residence.

Legal Reference:
18 NYCRR 430.11(c) or (d)

Action:
OCDSS and the contract agency will follow the FAD Certification when placing foster children in a given foster home.

Issue:
Adequacy of monitoring child/family while in foster care

Summary:
The DCP and PS were certified to take in 5 foster children, but at the time of the fatality had 8. All 8 foster children were removed from the DCP's foster home on a health and safety violation after a fatality occurred of another foster child who the DCP was providing daycare services for. The record reflected the home to be cluttered and to have exposed wiring and urine-soaked puppy pads accessible to the children. Parts of the ceiling were rotted due to water damage that had existed for an unknown amount of time. There was a crib located near a washer/dryer machine with the electric cords touching the crib and the outlet for that machine located on the wall right above the crib rail easily accessible to any child placed in that crib. A lofted bed for one of the foster children had a large, several pieced, extended baby gate wrapped around it. A second bed that was lower to the ground and used by a foster child had a baby gate pushed up against it creating a fire hazard. There were multiple dogs and litters of kittens in the home creating a foul odor. There were several baby bottles that appeared to have been used in the past found around the home. The record reflected the contract agency was in the DCP's home on 4/4/2023, 4/7/2023, and 4/12/2023 and documented the home appeared to be clean, safe and suitable for the children. The record did not reflect the contract agency addressed or noted any of the concerns at those home visits that initiated the health and safety removal of the foster children from the DCP's care on 4/26/2023.

Legal Reference:
18 NYCRR 441.21

Action:
OCDSS and the contact agency will monitor all foster children placed within their district in which they have a role in the Family Services Stage to ensure the children's needs for safety permanency and well-being are met.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
OCDSS documented that the 7yo FC was marked as a participant and a focus in an interview of the foster children on 4/26/2023; however, the record does not reflect details of the child's interview or that she was assessed. The child was on a trial discharge with her BF during this time. The 7yo FC was observed, but not interviewed on 5/4/2023 at the BF's home, despite being named as a maltreated foster child in a new CPS investigation.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS will incorporate key safety-related questions as they pertain to case circumstances. / The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/28/2022	Deceased Child, Male, 1 Days	Mother, Female, 39 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 1 Days	Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report dated 10/28/22 alleged that the BM gave birth the SC and upon delivery the BM tested positive for amphetamine and marijuana. Prior to giving birth to the SC, the mother had her rights terminated to one of her children and lost custody of her other children.

Report Determination: Indicated	**Date of Determination:** 02/14/2023

Basis for Determination:
OCDSS conducted interviews with the BM and several collateral contacts. OCDSS found that the BM had significant CPS history and did not have custody of any of her other children. The SC had a positive toxicology for illicit substances that were not prescribed to the BM. The BM was not appropriate in caring for the SC when in the hospital and would often fall asleep while holding the SC. The BM gave birth to a different child in 2017 who also was born with a positive toxicology and removed to foster care. That child was adopted in 2019. The SC was removed from the hospital due to BM's homelessness and substance misuse. A neglect petition was filed, and the SC was placed in foster care.

OCFS Review Results:
OCDSS made an adequate assessment of potential family placement options that BM offered except for one adult that the record reflected was not contacted. OCDSS consulted legal when necessary and made the appropriate decision to remove the newborn SC due to documented safety concerns. OCDSS did ask the BM for BF's information and BM declined, the record did not reflect any diligent efforts to locate the BF.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The BF was not added to the report or mailed a notification letter about the investigation. OCDSS asked the BM two consecutive days about the identity of the BF and BM declined to give information. No other diligent efforts were documented in the record to locate the birth father.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
OCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/05/2021	Other Child - stepchild of DCP, Male, 7 Years	Other Adult - unrelated adult, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - stepchild of DCP, Female, 11 Years	Other Adult - unrelated adult, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - stepchild of DCP, Female, 16 Years	Other Adult - unrelated adult, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - stepchild of DCP, Male, 7 Years	Other Adult - unrelated adult, Female, 42 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Other Child - stepchild of DCP, Female, 11 Years	Other Adult - unrelated adult, Female, 42 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
An SCR report alleged that on 8/5/21, the DCP's 16yo stepchild (OC) had a history of mental health concerns, suicidal ideations and long-term psychiatric hospitalizations. The 16yo OC had been physical with the 7yo and 11yo other step CHN resulting in bruises and marks. This aggression occurred in the home of the stepchildren's mother.

Report Determination: Unfounded	**Date of Determination:** 02/14/2023

Basis for Determination:
OCDSS interviewed the parents and children along with collateral contacts. OCDSS observed the children who did not

have any marks or bruises inflicted by 16yo OC. The 16yo OC has moved in with her BM and was enrolled in mental health services. The 7yo OC and 11yo OC resided full-time with their BF and the DCP. The new custody arrangement appeared to be working well for all the CHN.

OCFS Review Results:
OCDSS made referrals for mental health counseling and other community-based services for 16yo OC. The record reflected that the 7yo OC and 11yo OC were having behavioral issues, but the record did not reflect any referrals were offered for those children. The report was initiated on 8/5/2021 and the investigation did not close until 5/12/2021.

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

Issue:
Timeliness of Determination

Summary:
OCDSS initiated this report on 8/5/2021 and did not determine the case until 5/15/2022, the record reflected two 3-month gaps in casework activity.

Legal Reference:
SSL 424(7);18 NYCRR 432.2(b)(3)(iv)

Action:
OCDSS will make a determination of either "indicated" or "unfounded" within 60 days after receiving the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/11/2021	Other Child - DCP stepchild, Female, 16 Years	Day Care Provider, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	No
	Other Child - DCP stepchild, Female, 16 Years	Father, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged that on 5/11/21, the 16yo stepchild (OC) of the DCP, had expressed self-harm and the DCP and BF failed to seek treatment. The DCP and BF threatened the 16yo OC with physical force if she attempted to commit suicide.

Report Determination: Unfounded **Date of Determination:** 07/18/2021

Basis for Determination:
OCDSS interviewed the DCP, birth father, other children residing in the home, and collateral contacts. OCDSS found that the 16yo OC was in private counseling and her father and the DCP paid out of pocket for that. The 16yo OC was on medication and was compliant. The father and the DCP denied they harmed the child or made any threats towards child.

OCFS Review Results:
OCDSS conducted home visits and interviewed the household members and also the BM to the 16yo OC who reported no further concerns.

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

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

There were two unfounded investigations between 5/15/2018-12/31/2019 where the DCP was listed but had no role. The allegations listed were L/B/W, XCP, and IG against the DCP's paramour. Concerns were regarding allowing a sex offender to live in the home and spanking with excessive force.

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 105 days overdue.				
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: 11/03/2022
Date of placement with most recent caregiver? 11/03/2022
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:** 08/03/2022	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 08/08/2022	☒	☐	☐	☐
Was a check completed through the Staff Exclusion List? **Date:** 10/06/2022	☒	☐	☐	☐
Additional information, if necessary: No other information to provide.				

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?

☒Yes ☐No

Issue:	Adequacy of monitoring child/family while in foster care
Summary:	The SC was placed in Foster Care on 11/3/2022 via court order. A casework contact with the SC was made by the contract agency on 11/8/2022 and then not again until 12/8/2022.
Legal Reference:	18 NYCRR 441.21

Action:	For all foster care placements, the contract agency will, during the first 30 days of placement, hold casework contacts with the child as often as is necessary to implement the services tasks in the family and children's services plan but must occur at least twice.
Issue:	Reasonable and Prudent Parent Standard
Summary:	The contact agency was aware the SC's foster parents placed the SC in an illegal daycare setting starting at 5 days old with approximately 11 other children.
Legal Reference:	18 NYCRR 441.25
Action:	The contract agency will monitor the reasonable and prudent parent standard that must be applied by the foster parent with whom the child in foster care has been placed. The contact agency will monitor so that careful and sensible parental decisions that maintain the health, safety, and best interests of a child in foster care are being made.
Issue:	Timeliness of completion of FASP
Summary:	The comprehensive FASP was not completed on time. The FASP due date was 2/1/23, FASP was not completed until 5/11/23
Legal Reference:	18 NYCRR428.3(f)
Action:	The contract agency will complete timely and accurate FASPs.

Foster Care Placement History

The SC was placed in foster care after a judge ordered the removal from his biological mother before being discharged from the hospital after birth. The SC entered foster care due to the mother's current and past history of drug use, the subject child's positive toxicology and the mother's history of having children with positive toxicologies. The subject child remained in foster care until the time of his death.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No