Office of Children and Family Services

# Child Fatality Report

## Report Identification Number: NY-20-011

## Prepared by: New York City Regional Office

## Issue Date: Jul 20, 2020

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

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

☐ The death of a child for whom child protective services has an open case.

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

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

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

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

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

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

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

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

## Abbreviations

| | | |
|---|---|---|
| **Relationships** | | |
| BM-Biological Mother | SM-Subject Mother | SC-Subject Child |
| BF-Biological Father | SF-Subject Father | OC-Other Child |
| MGM-Maternal Grand Mother | MGF-Maternal Grand Father | FF-Foster Father |
| PGM-Paternal Grand Mother | PGF-Paternal Grand Father | DCP-Day Care Provider |
| MGGM-Maternal Great Grand Mother | MGGF-Maternal Great Grand Father | PGGF-Paternal Great Grand Father |
| PGGM-Paternal Great Grand Mother | MA/MU-Maternal Aunt/Maternal Uncle | PA/PU-Paternal Aunt/Paternal Uncle |
| FM-Foster Mother | SS-Surviving Sibling | PS-Parent Sub |
| CH/CHN-Child/Children | OA-Other Adult | |
| **Contacts** | | |
| LE-Law Enforcement | CW-Case Worker | CP-Case Planner |
| Dr.-Doctor | ME-Medical Examiner | EMS-Emergency Medical Services |
| DC-Day Care | FD-Fire Department | BM-Biological Mother |
| CPS-Child Protective Services | | |
| **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 | |
| **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 | ASTO-Allowing Sex Abuse to Occur | |

## Case Information

**Report Type:** Child Deceased
**Age:** 11 year(s)
**Jurisdiction:** New York
**Gender:** Female
**Date of Death:** 01/21/2020
**Initial Date OCFS Notified:** 01/21/2020

### Presenting Information

Per the OCFS-7065, the 11-year-old female child's death was due to a fire that occurred in the BM's home on 1/20/20. The child was transported to the hospital and died on 1/21/20.

### Executive Summary

The 11-year-old female child died on 1/21/20. As of 7/20/20, NYCRO had not yet received a copy of the autopsy report.

The family had an open foster care case at the time of the child's death.

ACS findings showed on 1/20/20, the child was in the BM's home on a Family Court approved extended home visit. The BF was reportedly in the basement of the BM's home. The BM was not in the home. At approximately 10:30 PM, the child was in her bedroom when a fire occurred in the home. The Fire Department of New York (FDNY) responded and found the child unconscious. She was transported to the hospital where she was pronounced dead.

The foster care agency submitted the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Services Cases. The information regarding the child's death was reported to OCFS under Chapter 485 of the Laws of 2006.

ACS attempted to interview the BM and BF about the case circumstances. The BM and BF informed ACS that they planned to travel with the child's body for burial in a foreign country. The foster care agency informed ACS that a maternal aunt said the BM and BF took the child's body to the foreign county. ACS and the foster care agency made several attempts to contact the BM and BF, however, they did not respond. The child had an adult female surviving sibling from the BF's previous relationship. There was no contact information for the adult sibling. There were no surviving children in the BM and BF's household.

ACS referred the case to the District Attorney's office and also interviewed FDNY, an assigned detective and the ME. The result of the interviews showed the cause of the fire was due to a space heater in the home, the child was found unconscious in her bedroom, there was no trauma to the child's body and the death was likely due to smoke inhalation. The ME said the final autopsy was pending toxicology results.

As of 7/20/20, the case remained open for further exploration.

## 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?** N/A

- **Was the determination made by the district to unfound or indicate appropriate?** N/A

**Was the decision to close the case appropriate?** N/A
**Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?** Yes
**Was there sufficient documentation of supervisory consultation?** Yes, the case record has detail of the consultation.

**Explain:**
As of 7/20/20, the case remained open.

**Required Actions Related to the Fatality**

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

| | |
|---|---|
| **Issue:** | Contact/Information From Reporting/Collateral Source |
| **Summary:** | ACS did not verify the official time the child was pronounced dead, and the location of the BM and BF at the time of the 1/20/20 incident. |
| **Legal Reference:** | 18 NYCRR 432.2(b)(3)(ii)(b) |
| **Action:** | ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed. |
| | |
| **Issue:** | Required data and official documents |
| **Summary:** | A data entry indicated that on 1/20/20 the child was discharged from foster care, and the reason was listed as "death." However, the progress notes reflected the child was alive on 1/20/20. |
| **Legal Reference:** | 428.3(b)(2)(i) |
| **Action:** | ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed. |
| | |

## Fatality-Related Information and Investigative Activities

**Incident Information**

**Date of Death:** 01/21/2020 **Time of Death:** Unknown

**Date of fatal incident, if different than date of death:** 01/20/2020
**Time of fatal incident, if different than time of death:** Unknown

**County where fatality incident occurred:** Kings
**Was 911 or local emergency number called?** Yes
**Time of Call:** Unknown
**Did EMS respond to the scene?** Unknown
**At time of incident leading to death, had child used alcohol or drugs?** Unknown
**Child's activity at time of incident:**

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

**Did child have supervision at time of incident leading to death?** Unable to determine

**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 | No Role | Female | 11 Year(s) |
| Deceased Child's Household | Father | No Role | Male | 54 Year(s) |
| Deceased Child's Household | Mother | No Role | Female | 50 Year(s) |

**LDSS Response**

According to the Family Services Progress Notes (FSPN), the foster care agency attempted to interview the BF by telephone on 1/21/20. The interview was unsuccessful because the BF informed the agency he was in a public office to make travel arrangements to transport the child's body for burial in a foreign country.

ACS interviewed the foster care agency and noted that on 1/20/20 the child was in the BM's home on an extended visit. The foster care agency said at approximately 10:30 PM, a fire occurred in the home and the preliminary findings showed the child died due to smoke inhalation.

ACS interviewed the BM on 1/21/20. The BM said on 1/20/20, she left the home at 10:04. However, the progress notes did not clarify whether the BM left the home during the morning or night. During the interview, the BM informed ACS that she asked the child to accompany her but the child wanted to remain in the home. The BM said the BF was in the basement of the home. According to the BM's account, there was no heat or hot water in the home, which was heated by portable heaters in different areas. The BM said she did not know how the fire started. She said she was unable to meet with ACS, and she refused to provide her location. She added that she was arranging to transport the child's body to a foreign country.

The FSPN reflected the child's body was released for the funeral which occurred on 1/21/20. The documentation showed the foster care agency attended the funeral, observed the BM seemed inconsolable, and determined it was inappropriate to speak with the BM. The BM and BF reportedly traveled with the child's body for the burial in a foreign country.

ACS held a case consultation and discussed the case circumstances. The result of the consultation showed the BM was

unwilling to discuss the child's death. ACS referred the case to the District Attorney's office for further processing.

FDNY contacted ACS and stated they were unable to discuss the case as LE investigation was in progress. ACS held a follow up meeting with LE, and verified the investigation was ongoing.

ACS interviewed the ME on 2/7/20. Per the ME's account, the child was home alone, there was no trauma to her body, and there was a high level of carbon monoxide in her blood as her death was likely due to smoke inhalation. The ME said the final autopsy was pending additional testing and results of the FDNY report to determine the cause of the fire.

On 2/13/20, LE informed ACS that the cause of the fire was due to a space heater. LE said there was no evidence of criminality and no arrest. LE added that the child was found unconscious in her bedroom in the home.

Between March and May of 2020, there was no casework activity in the case.

ACS contacted the ME's office and requested updated information about the autopsy on 6/5/20. ACS was informed that the autopsy was not yet finalized.

## Official Manner and Cause of Death

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

## Multidisciplinary Investigation/Review

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?** No
**Comments:** There is no OCFS approved Child Fatality Review Team in NYC.

## CPS Fatality Casework/Investigative Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **All children observed?** | ☐ | ☐ | ☒ | ☐ |
| **When appropriate, children were interviewed?** | ☐ | ☐ | ☒ | ☐ |
| **Contact with source?** | ☒ | ☐ | ☐ | ☐ |
| **All appropriate Collaterals contacted?** | ☐ | ☒ | ☐ | ☐ |
| Emergency Room Personnel | ☐ | ☐ | ☐ | ☒ |
| Pediatrician | ☐ | ☒ | ☐ | ☐ |
| **Was a death-scene investigation performed?** | ☒ | ☐ | ☐ | ☐ |
| **Coordination of investigation with law enforcement?** | ☒ | ☐ | ☐ | ☐ |
| **Was there timely entry of progress notes and other required documentation?** | ☒ | ☐ | ☐ | ☐ |

**Additional information:**

ACS was unable to visit the home because the BM and BF did not respond to ACS requesst for contact.

ACS did not obtain information from collateral contacts to verify the time of death and the BM and BF's location on 1/20/20.

## Fatality Safety Assessment Activities

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

## Legal Activity Related to the Fatality

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

## Services Provided to the Family in Response to the Fatality

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Other** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Additional information, if necessary:**
ACS was unable to offer services to the BM and BF as their whereabouts were unknown.

**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?** N/A
**Explain:**
There were no surviving children in the household.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** No
**Explain:**
The parents did not make themselves available for services.

## History Prior to the Fatality

### Child Information

**Did the child have a history of alleged child abuse/maltreatment?** Yes
**Was the child ever placed outside of the home prior to the death?** Yes
**Were there any siblings ever placed outside of the home prior to this child's death?** N/A
**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) |
|---|---|---|---|---|---|
| 08/07/2018 | Deceased Child, Female, 10 Years | Mother, Female, 48 Years | Inadequate Food / Clothing / Shelter | Substantiated | Yes |
| | Deceased Child, Female, 10 Years | Mother, Female, 48 Years | Parents Drug / Alcohol Misuse | Substantiated | |
| | Deceased Child, Female, 10 Years | Father, Male, 53 Years | Inadequate Food / Clothing / Shelter | Substantiated | |
| | Deceased Child, Female, 10 Years | Father, Male, 53 Years | Parents Drug / Alcohol Misuse | Substantiated | |

**Report Summary:**
The 8/7/18 report alleged the home was in a deplorable condition and a concern for the child. The home was cluttered with piles of garbage, and items obstructed the main entrance. A wall in the bedroom was completely stripped. The refrigerator was filthy and there was little food in the home.

**Report Determination:** Indicated | **Date of Determination:** 08/27/2018

**Basis for Determination:**
ACS substantiated the allegations of the report on the basis of credible evidence. ACS explained that there were

hazardous conditions in the home, and the family had insufficient food. ACS added that the BM and BF were observably impaired, they were incoherent and appeared disoriented, and the BF had slurred speech and staggered while walking.

**OCFS Review Results:**
ACS visited the home on 8/7/18 and 8/8/18 and found the conditions were hazardous to the safety of the child. The BF denied the allegations of the report, he was hostile and refused drug screening. The child was in the home and she did not have marks/bruises. The BM was not at home. ACS obtained Family Court intervention. The judge remanded the child to ACS and ordered foster care placement. The family sent the child to reside out of New York State, but following legal intervention, a resource person brought the child to the ACS Children's Center on 8/15/18.

ACS did not adhere to progress note entries requirement regarding the reporter/source information.

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

**Issue:**
Confidentiality of reporters

**Summary:**
ACS did not adhere to the reporter/source confidentiality guidelines for progress note entries, and thereby disclosed the identity of the source of the report.

**Legal Reference:**
SSL 422(4)(A); 05-OCFS-ADM-02

**Action:**
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 05/21/2018 | Deceased Child, Female, 10 Years | Mother, Female, 49 Years | Parents Drug / Alcohol Misuse | Unsubstantiated | Yes |

**Report Summary:**
The 5/21/18 report alleged the BM used crack cocaine and unknown prescription pills to impairment while being the sole caretaker for the child.

**Report Determination:** Unfounded | **Date of Determination:** 07/20/2018

**Basis for Determination:**
ACS unsubstantiated the allegation of the report on the basis of no credible evidence. ACS explained that the BM did not make herself available for random screening.

**OCFS Review Results:**
ACS visited the home, attempted to interview the BF and observed the child. The BF was coherent and sober, he refused ACS interviews, and he denied the allegations of the report. He denied the parents misused substances, and he said they did not experience mental health issues or DV incidents. The BM was not in the home during ACS visits, and her whereabouts were unknown. ACS contacted the child's school and interviewed personnel who said the child attended school but refused to complete any assignments. ACS sought legal consultation and was advised there was no basis to file an Article Ten Neglect petition. Some events occurred on 5/25/18 but were not entered until 7/20/18.

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

**Issue:**
Timely/Adequate Case Recording/Progress Notes

**Summary:**

ACS did not contemporaneously enter progress notes. Some events occurred on 5/25/18, 5/30/18 and 6/6/18 but were not entered until 7/20/18, 7/12/18 and 7/19/18.

**Legal Reference:**

18 NYCRR 428.5

**Action:**

ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 03/15/2018 | Deceased Child, Female, 10 Years | Mother, Female, 38 Years | Inadequate Food / Clothing / Shelter | Far-Closed | Yes |
| | Deceased Child, Female, 10 Years | Mother, Female, 38 Years | Inadequate Guardianship | Far-Closed | |
| | Deceased Child, Female, 10 Years | Mother, Female, 38 Years | Lack of Supervision | Far-Closed | |
| | Deceased Child, Female, 10 Years | Mother, Female, 38 Years | Parents Drug / Alcohol Misuse | Far-Closed | |
| | Deceased Child, Female, 10 Years | Father, Male, 52 Years | Inadequate Food / Clothing / Shelter | Far-Closed | |
| | Deceased Child, Female, 10 Years | Father, Male, 52 Years | Inadequate Guardianship | Far-Closed | |
| | Deceased Child, Female, 10 Years | Father, Male, 52 Years | Lack of Supervision | Far-Closed | |

**Report Summary:**

The SCR report alleged the BM and BF abused crack to impairment in the presence of the child. The BM and BF often became incoherent and unable to provide adequate care for the child. There was not adequate food in the home. The BM and BF left the child home alone for undetermined lengths of time.

**OCFS Review Results:**

ACS observed the child in school on 3/16/18 and at home on 3/19/18. The progress notes showed the child provided information indicating the BM and BF misused drugs in the home but later she denied knowledge of drug use in the home. The BM and BF denied the allegations of the 3/15/18 report and they refused referral for substance screening. The BM took the child to a foreign country from 3/26/18 through 4/13/18. ACS observed the child in the home on 4/16/18 but did not include a home observation/safety assessment in the progress note.

Due to information received from collateral contacts and the BM and BF's refusal for services, ACS assigned the FAR to a CPS investigation.

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

**Issue:**

FAR-Failure to Provide Notice of FAR Closure

**Summary:**

ACS did not provide Notice of FAR Closure to the BM and BF who were identified in the 3/15/18 report.

**Legal Reference:**

18 NYCRR 432.13 (e)(2)(viii)

**Action:**
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

**Issue:**
FAR-Overall Completeness/Adequacy of Family Assessment Response

**Summary:**
The progress notes did not include adequate details about ongoing safety assessments of the child. There was a lack of details about the BF's disclosure of his pre-existing medical condition and illness, and hospitalization plan, the home conditions, child safety assessment for the 4/16/18 and other visits, and the BM's period of incarceration that was referenced in the progress notes.

**Legal Reference:**
18 NYCRR 432.13 (a)(1-4)

**Action:**
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 04/09/2017 | Deceased Child, Female, 9 Years | Mother, Female, 47 Years | Inadequate Food / Clothing / Shelter | Substantiated | Yes |
| | Deceased Child, Female, 9 Years | Mother, Female, 47 Years | Lacerations / Bruises / Welts | Unsubstantiated | |
| | Deceased Child, Female, 9 Years | Father, Male, 51 Years | Inadequate Food / Clothing / Shelter | Substantiated | |
| | Deceased Child, Female, 9 Years | Father, Male, 51 Years | Lacerations / Bruises / Welts | Unsubstantiated | |

**Report Summary:**
The 4/9/17 report alleged for an unknown amount of time, the BM and BF resided in their car with the child. The child had suspicious bruises on her face, and the explanation provided was not consistent with the nature of the injury.

**Report Determination:** Indicated | **Date of Determination:** 06/09/2017

**Basis for Determination:**
ACS substantiated the allegation of IF/C/S of the child on the basis the BM and BF were unable to verify they had adequate living space for the child.

ACS unsubstantiated the allegation of L/B/W on the basis of no credible evidence.

**OCFS Review Results:**
ACS found the child resided out of New York State but was visiting the BM when the BM "shoplifted." The BM was examined in the ER for psychiatric concerns. ACS interviewed the physician and BM, and observed child in the ER on 4/10/17. The physician said the child sustained superficial injuries to her face, and there was no medical treatment required. The BM said she resided in a car. The BF visited the BM and child in the ER and he informed ACS that the child resided out of New York State.

The child returned to the out of New York State caretaker through a family arrangement. However, the RAP did not reflect the child was in the care of a substitute caregiver prior to 4/9/17.

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

**Issue:**
Adequacy of Risk Assessment Profile (RAP)

**Summary:**
ACS completed a RAP on 5/1/17. However, the RAP did not reflect the child was in the informal care of a substitute caregiver prior to the 4/9/17 report. The RAP did not include information about the BM and BF's unstable housing condition although ACS progress notes showed the parents did not have adequate living space for the child.

**Legal Reference:**
18 NYCRR 432.2(d)

**Action:**
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

[redacted]

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

The BF was a subject in reports dated 10/28/96 and 1/21/02. The allegations of IG, IF/C/S, LS, Other and PD/AM by the BF were substantiated.

The BM was an alleged subject in a SCR report that was registered on 1/9/11. The allegations of the report were IG and PD/AM of the child by the BM. ACS unsubstantiated the allegations of the report.

## Known CPS History Outside of NYS

ACS case record reflected that in December 2011, an international social services agency requested an assessment of the BM's home and referral for services. The documentation showed the agency removed the child from the BM's care, and following the reunification the BM and child relocated to New York. ACS discussed the agency's request with the BM who said she no longer resided in New York State. The BM said she planned to return to the foreign country. The progress notes showed ACS was unable to assess the home or provide services.

## Family Assessment and Service Plan (FASP)

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Was the most recent FASP approved on time?** | ☒ | ☐ | ☐ | ☐ |
| **Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?** | ☒ | ☐ | ☐ | ☐ |

## 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:** 08/13/2018

**Date of placement with most recent caregiver?** 02/05/2019
**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:** 07/19/2016 | ☒ | ☐ | ☐ | ☐ |
| **Was a check completed through the State Central Register?** **Date:** 07/05/2016 | ☒ | ☐ | ☐ | ☐ |
| **Was a check completed through the Staff Exclusion List?** **Date:** 01/19/2017 | ☒ | ☐ | ☐ | ☐ |
| **Additional information, if necessary:** As of 7/20/20, the case remained open. | | | | |

## 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 progress notes did not include information to assess ACS monitoring of the child, who was in LDSS custody. |
| **Legal Reference:** | 18 NYCRR 441.21 |
| **Action:** | ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.. |
| | |
| **Issue:** | Timely/Adequate Case Recording/Progress Notes |
| **Summary:** | The foster care agency (referred to as OHEL) did not contemporaneously enter progress notes. Some events occurred on 3/6/19, 8/1/19 an 9/9/19 but were entered on 5/1/19, 9/25/19 and 10/31/19. |
| **Legal Reference:** | 18 NYCRR 428.5 |
| **Action:** | OHEL must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. OHEL must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed. |
| | |

## Foster Care Placement History

The child resided in non-kinship foster boarding homes with OHEL agency. The FSPN showed she received therapeutic

services to address her impulsive, defiant and difficult behavior, and the BM completed a substance abuse program in June 2019. The BM reportedly enrolled in therapeutic services but was discharged due to non-compliance. The BF enrolled in treatment readiness, parenting and relapse prevention services and was discharged for low attendance. The BF said he resided in a friend's home. In April 2019, the judge directed the child be released to the BM. However, the BM said she was ill and not ready to care for the child. As a result, the child remained in foster care with weekend and overnight home visits until an extended home visit began in October 2019. The judge approved the continuation of the extended home visit during the 11/25/19 hearing.

Per the FSPN, the agency made announced visits to the BM's home. During the 12/30/19 visit, OHEL found all smoke detectors were working. There was no hot water in the home, the BM used several portable heaters and the home temperature was warm. OHEL met with the child and therapist at the clinic on 1/16/20. The FSPN showed the child had no visible marks/bruises, she wore appropriate clothing, and the BF was in the clinic's waiting room.

## 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:** |
| 08/09/2018 | There was not a fact finding | Widthdrawn |
| **Respondent:** | 054368 Mother Female 50 Year(s) | |
| **Comments:** | Following the child's death, the case was withdrawn without prejudice. | |

| **Family Court Petition Type:** FCA Article 10 - CPS | | |
|---|---|---|
| **Date Filed:** | **Fact Finding Description:** | **Disposition Description:** |
| 08/09/2018 | There was not a fact finding | Widthdrawn |
| **Respondent:** | 054369 Father Male 54 Year(s) | |
| **Comments:** | Following the child's death, the case was withdrawn without prejudice. | |

## 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