Child Fatality Report

Report Identification Number: NY-23-071

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

Issue Date: Dec 08, 2023

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 07/19/2023
Initial Date OCFS Notified: 07/19/2023

Presenting Information

An SCR report received on 7/19/23 alleged that on 7/18/23, around 1:00PM, the mother was giving the subject child a bath. The mother left the child in the bathtub unsupervised for an unknown amount of time with the water running to attend to a sibling. When the mother returned, she observed the child face-up in the bathtub, not breathing, and unresponsive. The mother sought help, and a shelter staff member attempted CPR. The child was transported to the hospital in full cardiac arrest and was intubated. The child was then transferred to a pediatric intensive care unit, where his condition worsened, and he was pronounced deceased on 7/19/23. A subsequent SCR report was received 7/20/23 and further explained the child suffered an anoxic brain injury and died on 7/19/23 at 3:23PM. Additionally, in May 2023, the father used an extension cord to hit the sibling.

Executive Summary

This report concerns the death of the 6-month-old subject child. The Administration for Children's Services (ACS) received two SCR reports regarding the child's death, which occurred on 7/19/23. These reports, received 7/19/23 and 7/20/23 respectively, were subsequent to two SCR reports received on 7/18/23 following the incident leading to the child's death. In addition to the two open investigations initiated on 7/18/23, the family was involved in a CPS monitored services case, opened 5/25/23 following an indicated 5/13/23 SCR report. At the time of the child's death, he resided with his mother and two siblings, ages 2 and 3. The family resided in a shelter.

On 7/18/23, the mother had been sleeping with the subject child. When she woke up around 1:00PM, she noticed the child had soiled himself and his clothes. The mother took his clothes off and put him in an infant tub, which was placed inside the bathtub. While giving the child a bath, the 3-year-old sibling yelled to the mother that he was hungry, and the mother saw him climb onto the counter. The mother ran out of the bathroom to attend to the sibling and when she returned to the bathroom 2 to 3 minutes later, she noticed the subject child floating, face-up. The mother took the child out of the tub and yelled out for assistance. The mother could be heard yelling "call 911" out of the window. Shelter security responded to the unit at 1:04PM and found the mother holding the child. Shelter staff administered CPR. EMS arrived and the child was brought down to them. EMS took over life-saving measures and transported the child to the hospital. The child was intubated and transferred to a second hospital for a higher level of care and was placed on life support. On 7/19/23, the child's heart rate and blood pressure began fluctuating and he experienced multi-organ failure. The child was pronounced dead at 3:23PM.

The medical examiner was notified and performed an autopsy. The record reflected the medical examiner stated the child suffered an anoxic brain injury, likely due to complications of drowning; however, the official cause and manner of death were pending at the time the CPS investigation was closed. While the external exam was unremarkable, an internal exam found a hemorrhage and hematoma in the muscle underneath the child's scalp. The hemorrhage was on the right side of the head. Further evaluation revealed a nondisplaced linear fracture of the skull in that same area, about 7cm in length. There was an epidural hemorrhage associated with the fracture. Further testing was ordered to look for signs of nonaccidental trauma and to better date the injury. The findings were shared with law enforcement. Law enforcement re-interviewed the mother, who made no additional disclosures. ACS did not interview the mother or the father regarding these findings. No arrests related to the fatality were made.

The mother was interviewed at the precinct following the fatal incident. The father was not interviewed. ACS assessed the siblings to be in immediate and impending danger and they were removed and placed with a relative resource. An Abuse

petition was filed on 7/21/23. At the time this report was written, family court was ongoing, and the siblings remained in foster care, though were placed in an agency foster home as their relative no longer wished to provide care.

ACS substantiated the allegations of IG, LS, and DOA/Fatality against the mother regarding the subject child. The allegation of IG against the mother for the siblings was unsubstantiated despite being substantiated in the 7/18/23 investigations for the same event. The allegation of IG against the father was attributed to the wrong sibling, therefore resulting in an inaccurate determination, as the event had also been previously substantiated in May 2023.

Due to the siblings' foster care placement and ongoing case needs, the services case remained open.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** 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:
The investigation was correctly indicated; however, not all allegations were determined appropriately. The allegations concerning the siblings were incorrectly unsubstantiated. Those allegations referred to previously investigated and substantiated concerns and should have therefore been substantiated.

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:
The services case open at the time of the fatality remained open, as the siblings remained in foster care at the time the CPS investigations into the fatal event and subsequent fatality were closed. Having concurrent investigations open at the same time created the opportunity for a disorganized case record that did not accurately reflect all casework activities and requirements.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	New information became apparent during the open case regarding the subject child being found at autopsy to have additional injuries; including a skull fracture, hemorrhaging, and a hematoma. Neither of the parents were interviewed by ACS about this.
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:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The father was not interviewed. The mother was interviewed about allegations only in the 7/18/23 investigation; however, the interview was not documented in the fatality investigation, nor was a new interview documented.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.
Issue:	Appropriateness of allegation determination
Summary:	The allegation of IG against the mother for the SSs was Unsub, despite referring to an incident previously Sub. The allegation of IG against the father was attributed to the wrong SS, and Unsub despite referring to a prior incident previously Sub.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the NYC Regional Office if further guidance is needed.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP was scored that the BM prioritized the CHN's needs above her own, but she would not visit them in foster care. The safety assessment reflected the BM's MH placed the CHN in immediate/impending danger, but the RAP was scored no MH existed.
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.

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	ACS maintained two fatality investigations. Although progress notes can be copied between investigations, maintaining two separate records in this case led to fragmented case recording and duplication in the record.
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:	Timely/Adequate Seven Day Assessment
Summary:	The Seven Day Safety Assessment was not completed timely in either fatality investigation.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS will document and approve all safety assessments within the required timeframes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/19/2023 **Time of Death:** 03:23 PM

Date of fatal incident, if different than date of death: 07/18/2023
Time of fatal incident, if different than time of death: 01:00 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 01:07 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

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	6 Month(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	31 Year(s)

LDSS Response

ACS initiated their investigation upon receipt of the 7/18/23 SCR reports regarding the fatal incident. The sources of all SCR reports were contacted, relevant collateral contacts were made, the DA was notified, and a CPS history check was documented. The safety of the siblings was assessed, and the siblings were removed following the fatality. The record reflected inconsistent removal dates; however, the removal was upheld in family court on 7/21/23.

The mother was interviewed following the fatal incident on 7/18/23. The mother said she had been asleep with the subject child. When she woke up, she noticed the child had soiled himself and his clothes were dirty. She took his clothes off and placed him in a baby tub, inside of the bathtub. The mother said while she was giving him a bath, she heard the 3yo sibling call out that he was hungry and saw him climb onto the kitchen counter. The mother then ran out of the bathroom to attend to the sibling, who was on the counter with the stove on. The mother turned the stove off, got the sibling off the counter, and gave him a snack. The mother returned to the bathroom and noticed the subject child was floating, face-up. The mother said she was gone from the bathroom 2 to 3 minutes. The mother picked the child up out of the tub and yelled for assistance. The mother was frantic and unable to find her phone. While holding the child, the mother ran out of the family's shelter unit, screaming and banging on neighbors' doors. Shelter staff met the mother and began CPR while waiting for EMS to arrive. EMS took over life-saving measures and transported the child to the hospital. The father was not present for the incident and was not interviewed.

ACS spoke with shelter staff who confirmed the mother's account of events. The mother could be heard yelling for help around 1:00PM. Around 1:04PM, shelter staff responded to the family's unit and found the mother holding the child, who appeared lifeless, limp, and unresponsive. Staff called 911 and attempted CPR. Staff said there was a lot of water on the bathroom floor, but none in the bathtub.

The hospital was contacted upon the child's admission on 7/18/23 and it was learned at that time the child had lost oxygen to his brain for about an hour, was intubated, and required a higher level of care. On 7/19/23, the child experienced multi-organ failure and passed away. ACS was notified by the mother of the child's death.

Upon learning of the subject child's internal injuries from the ME, ACS confirmed with LE that they had also been made aware. LE reported they re-interviewed the mother, and no further disclosures were made. The record did not reflect if the father was interviewed by LE or ACS regarding the injuries. The ME was not directly asked about the cause of the injuries; however, ACS conferred with the child abuse specialist at the hospital who stated the muscle hemorrhaging observed would have been caused by a blunt surface hitting the child on the right side of the head. The injuries to the child's head would have been caused by the mother falling on the child. The injuries found were never previously disclosed. The siblings were assessed for injuries at the hospital; no injuries were noted for the 3yo and the previously reported mark on the 2yo was observed but there were no additional injuries found.

On 7/21/23, ACS filed an Article 10 Abuse petition against the mother, which was heard in family court on that date. The siblings had been removed prior to filing and the removal was upheld. The siblings had been placed with a paternal grandmother; however, the grandmother no longer wished to provide care to her grandchildren, and they were placed into foster care. The corresponding service case remained open at the time this report was written.

Bereavement services and funeral assistance was offered to the mother. The father was referred to services in his service plan, but it was not reflected if bereavement referrals were made.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: The New York City area does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065104 - Deceased Child, Male, 6 Mons	065105 - Mother, Female, 24 Year(s)	DOA / Fatality	Substantiated
065104 - Deceased Child, Male, 6 Mons	065105 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
065104 - Deceased Child, Male, 6 Mons	065105 - Mother, Female, 24 Year(s)	Lack of Supervision	Substantiated
065106 - Sibling, Male, 3 Year(s)	065105 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
065106 - Sibling, Male, 3 Year(s)	065108 - Father, Male, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
065107 - Sibling, Male, 2 Year(s)	065105 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated

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?	☒	☐	☐	☐

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 siblings were assessed to be in immediate and impending danger and in response, ACS conducted an emergency removal. An Abuse petition was filed in family court on 7/21/23, outlining the numerous injuries found to the subject child during the autopsy. Based on the severe abuse of the subject child, the siblings were considered derivatively abused. The removal was upheld at that time and the siblings remained in foster care.

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:**
07/21/2023	There was not a fact finding	Foster Care Placement to Continue
Respondent:	065105 Mother Female 24 Year(s)	
Comments:	Article 10 Abuse petitions against the mother, on behalf of the subject child and siblings were filed on 7/21/23. As a result, the siblings were remanded to ACS and placed with a paternal relative. The mother was permitted supervised visits by the approved relative resource. The father had previously been ordered to have supervised visits as a result of a 5/15/23 Article 10 Neglect petition, which had been filed in response to the 5/13/23 CPS investigation. Family court proceedings were ongoing and a fact finding hearing was scheduled for March 2024.	

Have any Orders of Protection been issued? Yes	
From: 07/21/2023	**To:** Unknown
Explain: As a result of the filing of the Article 10 Abuse petition, the mother was ordered to have supervised visitation with the siblings.	

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:
In response to the fatal incident, the siblings were removed and placed initially with a relative resource and then ultimately into foster care to address their immediate safety needs. The siblings were 2 and 3 years old at the time of the fatality and a service need specific to the subject child's death was not identified.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother initiated mental health services during the investigation. ACS confirmed the mother's counselor was aware of the fatality and able to provide bereavement services; however, the services case reflected the mother was residing out of state by September 2023. It was unknow if she had engaged in counseling services. Funeral assistance was offered to the family. The father was provided service referrals; however, it remained unknown if he engaged in bereavement specific services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs
☐ Used prescription drugs
☒ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/18/2023	Sibling, Male, 2 Years	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 6 Months	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 6 Months	Mother, Female, 24 Years	Lack of Supervision	Substantiated	
	Sibling, Male, 2 Years	Father, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Father, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
Two SCR reports were received on 7/18/23. The first alleged that on that date, the mother was bathing the subject child in the bathtub. One of the siblings was playing with the stove and the mother left the subject child unattended in the bathtub to go to the kitchen. When the mother returned 2-3 minutes later, she found the child unresponsive. The bathtub had little water in it. The mother had someone call 911 and the child was transported to the hospital. The second report was concerning the same incident. In addition, the report alleged that four months ago, the father physically assaulted one of the siblings, though further details were unknown.

Report Determination: Indicated | **Date of Determination:** 08/03/2023

Basis for Determination:
The Investigation Conclusion Narrative stated the allegations of IG and LS against the mother for the subject child were substantiated, as the mother left the child unattended in the bathtub. The child was subsequently found unresponsive and succumbed to his injuries on 7/19/23. IG was substantiated against the mother regarding the siblings due to the incident with the subject child. No additional basis for the determination pertaining to the siblings was documented. The

allegation of IG was unsubstantiated against the father, stating he was not involved in the incident that took place as he was not residing in the home at the time of the incident.

OCFS Review Results:
Two investigations ran concurrently. The records reflected the mother was interviewed about allegations only and an interview with safety-related questions was not documented. Attempts to interview the father were unsuccessful. The safety assessments reflected the mother disclosed a history of DV with the father that was not otherwise documented in the record, and previously denied in the May 2023 investigation. The siblings were removed and placed with a relative, although the progress note corresponding to this event was not recorded. The family services stage and two investigations into the fatality remained open at the time these investigations were determined and closed.

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The mother was interviewed about allegations only; a full interview was not documented. The safety assessment reflected DV concerns not otherwise explored.

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

Action:
ACS will incorporate key safety-related questions as they pertain to case circumstances.

Issue:
Appropriateness of allegation determination

Summary:
The allegation of Inadequate Guardianship against the father was unsubstantiated regarding the now 2 and 3yo siblings because the father was “excluded from the house” at the time of the report; however, the allegation was referring to a prior incident, which was previously substantiated regarding the now 2yo sibling.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the NYC Regional Office if further guidance is needed.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/13/2023	Sibling, Male, 1 Years	Father, Male, 31 Years	Excessive Corporal Punishment	Substantiated	No
	Sibling, Male, 1 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Father, Male, 31 Years	Lacerations / Bruises / Welts	Substantiated	
	Sibling, Male, 1 Years	Father, Male, 31 Years	Swelling / Dislocations / Sprains	Substantiated	
	Sibling, Male, 3 Years	Father, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
ACS received four SCR reports on 5/13/23 regarding the incident. The initial report stated, on 5/13/23, the father physically assaulted the sibling. The father hit the sibling on the back with a phone charger, causing a mark. As a result of the father’s behavior, the sibling required medical attention. The second report added the father had a history of using excessive force on the sibling. The third report specified visible injuries were left on the sibling’s chest and back. The

fourth report alleged the father beat the sibling with the phone charger cord on his back, back of his legs, and near his groin area and as a result the sibling sustained swelling, welts, and abrasions.

Report Determination: Indicated | **Date of Determination:** 07/07/2023

Basis for Determination:
The allegations of Excessive Corporal Punishment, Inadequate Guardianship, Lacerations/Bruises/Welts, and Swelling/Dislocations/Sprains were substantiated against the father regarding the now 2-year-old sibling. The Investigation Conclusion Narrative stated the father beat the sibling with a charging cord and left marks and bruises on his body. It was also reported that the sibling had swelling to certain areas of his body. Additionally, ACS concluded the father was unable to meet the sibling's basic needs. The allegation of Inadequate Guardianship was unsubstantiated regarding the now 3-year-old sibling stating there was not enough evidence to suggest the allegation was true.

OCFS Review Results:
A quick succession of SCR reports was received. The father was arrested on 5/13/23 and an Order of Protection was issued. Family court was accessed on 5/15/23 and an Article 10 petition was filed and an Order of Supervision issued, though the content was not documented. ACS observed the marks on the sibling and confirmed with medical collaterals the marks were consistent with being hit by a phone charger. Out of state CPS history was checked, although one state had not responded at the time the CPS investigation closed. Service referrals were made, and a family services stage was opened. Early Intervention referrals were not documented despite the indication and children's ages.

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

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 NYS. In previous investigations, it was learned the family resided in two other states. Both states were contacted to assess prior CPS history at that time. One state responded with no history, and one state did not respond.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 05/25/2023

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☐	☒	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☐	☒	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Adequacy of Progress Notes
Summary:	Progress notes did not contain adequate descriptions of efforts made to engage the family in the development of the service plan, actions taken prior to and at removal, court hearings, or all casework contacts.
Legal Reference:	18 NYCRR 428.5
Action:	ACS will accurately document all casework activity into progress notes.

Preventive Services History

The family was involved in a services case (FSS) at the time of the fatality. The FSS was opened on 5/25/23 listing the mother, father, subject child, and siblings. Prior to the fatality and the siblings' removal, case recording in the FSS was limited and did not adequately reflect ongoing casework activity. The subject child was removed from the FSS following his death. On 7/18/23, the siblings were placed with the paternal grandmother. The grandmother was no longer willing to provide care to the siblings, and they were re-placed on 8/18/23 to the Children's Shelter until they were placed into a foster home on 8/24/23.

The service plan reflected the father needed to engage in parenting skills and anger management. The father was to start parenting skills in October 2023. The status of referrals for anger management was unknow. The mother was also to engage in parenting skills and counseling. The status of her involvement in recommended services was unknown. The record reflected as of September 2023 the mother was residing out of state. Both parents were offered supervised visitation, and the father was visiting with the siblings. At the time this report was written, the siblings remained in foster care and family court proceedings were ongoing. The FSS remained open with a contract agency.

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:**
05/15/2023	There was not a fact finding	Order of Supervision
Respondent:	065108 Father Male 31 Year(s)	
Comments:	ACS filed a Neglect petition against the father on 5/15/23 on behalf of the children. The petition was in response to the 5/13/23 CPS investigation, in which the father used a phone charger to hit the now 2-year-old sibling. The child was observed with marks consistent with using a phone charger. The father was ordered to leave the home and an Order of Protection had been put in place on behalf of the children. The father was permitted supervised visitation. The expiration date of the order was unknown. The children were permitted to stay in the care of the non-respondent mother.	

Criminal Charge: Assault **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
05/13/2023	Father	05/13/2023	Order of Protection
Comments:	On 5/13/23, the father hit the now 2-year-old sibling with a cord, causing the sibling to sustain marks and bruises about his body. The father was arrested and charged with Assault in the 2nd degree and Endangering the Welfare of a Child. An Order of Protection on behalf of the subject child and siblings was granted.		

Have any Orders of Protection been issued? Yes	
From: 05/13/2023	**To:** Unknown

Explain:
An Order of Protection was issued against the father on behalf of the subject child and siblings on 5/13/23, following the father's arrest for the use of excessive corporal punishment against the now 2-year-old sibling. The Order was a stay away order with a carve out for court-ordered visitation.

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