Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-079

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

Issue Date: Jan 28, 2025

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: 11 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 08/14/2024
Initial Date OCFS Notified: 08/14/2024

Presenting Information

On 8/14/24, an SCR report was received alleging the mother put the 11-month-old subject child in the bathtub filled with water to bathe, then left the subject child unsupervised in the tub for 1-2 hours. At an unknown time, the mother returned to the bathroom and found the subject child unresponsive. The mother brought the subject child into the hallway and called 911. When EMS arrived, CPR was performed, and the subject child was transported to the hospital. The subject child was pronounced deceased at 8:25PM.

A subsequent report was received on the same day alleging the mother left the subject child and surviving siblings unsupervised for an unknown period of time. At approximately 8:00PM, the subject child was found in the bathtub by an unknown adult. The adult performed CPR until EMS arrived; however, attempts were unsuccessful.

Executive Summary

This report concerns the death of the 11-month-old female subject child that occurred on 8/14/24. The New York City Administration for Children's Services (ACS) received two SCR reports on that same date, regarding the fatality. The SCR reports contained allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision. Allegations of Emotional Neglect, Lacerations/Bruises/Welts, and Parent's Drug and Alcohol Misuse were added against the subject mother during the investigation. At the time of her death, the subject child resided with the subject mother and two surviving siblings, aged 4 and 2 years.

The family was engaged in Preventive Services when the fatality occurred. The Preventive Services Case was opened after a domestic violence incident in which the father became physically violent with the subject mother. The incident resulted in the subject mother requiring emergency medical treatment. On 7/26/24, ACS filed an Article 10 Neglect petition against the father; an Order of Protection was issued, and the children were released to the subject mother with supervision. The father did not reside in the home when the fatality occurred.

On the night of 8/14/24, the subject child was found unresponsive in a bathtub. The subject mother took the subject child out of the tub and ran into the hallway calling for help. Neighbors attempted life-saving measures and called 911. EMS responded to the scene and the subject child was transported to the hospital where she was pronounced deceased at 8:25PM.

Following the fatality, an emergency removal of the surviving siblings was conducted. A medical assessment was completed before the surviving siblings were placed in a kinship home. During the medical assessment abrasions and bruising were found on the face, buttock, and thigh of the 2-year-old surviving sibling. The doctor was unsure how the injuries were inflicted; the 4-year-old surviving sibling and the subject mother said she fell off a bike. The injuries did not appear fresh, the doctor believed they were a few days old. A second review of the SS's medical assessment by a Child Abuse Pediatrician determined the injuries observed on the 2-year-old surviving sibling were not consistent with the child falling off a bike and were indicative of physical abuse. Additionally, the 2-year-old SS's startle response and seeking emotional support from strangers indicated abuse/neglect by the caregiver. Therapy was recommended. There were no medical findings on the 4-year-old surviving sibling.

Law enforcement received conflicting accounts of the night of the incident; however, as of this writing no arrests had been made, and the criminal investigation remained open. The medical examiner determined the cause of death to be drowning, and the manner of death was ruled a homicide.

ACS offered bereavement services to the family in addition to referrals for identified service needs. ACS was unable to interview or assess for the service needs of the subject mother due to her attorney directing her not to interact with ACS.

There were no documented efforts in the case record to contact the 4-year-old surviving sibling's biological father. The case record stated a home visit took place on 8/13/24, the day before the fatality, and documentation stated there were no marks/bruises observed on the children during this visit. On 8/14/24, the 2-year-old surviving sibling was found to have abrasions and bruises on her face and body that were medically assessed to "appear to be several days old."

The investigation was closed, and the allegations referenced above were substantiated against the subject mother. ACS substantiated the allegations regarding the surviving siblings due to the findings in the medical assessment, and the additional review made by the Child Abuse Pediatrician. There was a fair preponderance of evidence documented in the case record that demonstrated the subject mother's lack of supervision and inadequate guardianship caused and/or contributed to the subject child's death. However, documentation in the case record does not clearly demonstrate the subject mother’s alleged substance use had a role in the subject child’s death, or created a condition that placed the children’s physical, mental or emotional condition in imminent danger of becoming impaired. A services case remained open due to the sibling’s continued placement in foster care.

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?** No, sufficient information was gathered to determine some allegations only.

- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
There was not a fair preponderance of evidence to substantiate allegations of PD/AM.

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 CPS investigation was closed; however, the case remained open for services.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Progress Notes
Summary:	There was information present in the final safety assessment regarding the SM's mental health that was not present in the case record. It was unknown where, or from who, the information was obtained.
Legal Reference:	18 NYCRR 428.5
Action:	ACS will accurately document all casework activity into progress notes.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The 4yo SS's father was not contacted, nor were efforts made to locate or contact him documented in the case record.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make 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:	Contact/Information From Reporting/Collateral Source
Summary:	It was documented in the case record that the source of the report was not the person who witnessed the SM overly intoxicated and unable to care for the children, it was another person known to the family. However, there were no documented efforts of ACS's attempts to contact the witness.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.
Issue:	Appropriateness of allegation determination

Summary:	ACS substantiated allegations of PD/AM without a fair preponderance of evidence. There was no documentation in the case record that the SM was observed to be under the influence, or any positive drug screens obtained during the investigation. However, the PD/AM allegation details listed the SM was substantiated for marijuana, PCP, and cocaine use. Collateral contacts reported there were concerns about the SM's substance use, however, there were no descriptions provided by collaterals of the SM observed under the influence.
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 NYCRO if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/14/2024 **Time of Death:** 08:25 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 07:41 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: 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	Female	11 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)

Other Household 1	Father	No Role	Male	41 Year(s)

LDSS Response

On 8/14/24, ACS received the report from the SCR and initiated the investigation. ACS collaborated with the multi-disciplinary team and made diligent efforts to locate the surviving SSs to assess safety. The SSs were located on 8/14/24, when an additional information report was received that identified their whereabouts.

ACS contacted LE who reported the SM had been interviewed and provided multiple conflicting stories. The SM reported to LE that she took the SC to pick up the SSs from daycare at 6:15PM, then went to the grocery store with a friend. Upon return, the SM put the groceries away before bathing all 3 children. The SM stated she took the SSs out of the bathtub first, leaving the SC in the bathtub full of water for about 10 minutes. When the SM returned to the bathroom, she found the SC unresponsive. LE did not believe this description of events was consistent with the video recording obtained from the property. The recording showed the SM leaving the case address without children at 6:11PM and returning to the case address at 6:36PM with the SSs, two neighbors, and groceries. At 7:38PM, the recording showed the 2 neighbors exit the apartment, and at 7:39PM the SM was seen running out of the apartment with the SC in her arms. LE did not believe the SM would have had time to bathe 3 children in the timeframe seen in the video. LE noted the SM was seen in the video recording throughout the day of the incident leaving and returning to the home without the SC from 9:58AM-8:00PM. LE also noted the SM provided EMS on the scene a different version of events. Per LE, the SM told EMS she had left the SC at home for an hour or two, before she returned home around 6:15PM, and put all three children in the bathtub for about an hour. When the SM returned to the bathroom, she found the SC unresponsive.

ACS attempted to interview the SM; however, were unsuccessful due to the SM's attorney instructing her not to speak to ACS. The SM's account of the events leading up to the fatality remained unknown.

A phone interview was conducted with the BF who was not present for the fatal incident. The BF stated he got a phone call from the SM telling him the SC had passed away and he needed to get to the hospital. The BF stated the SM did not share what happened over the phone but told him more at the hospital. However, the BF stated he could not remember what the SM said at the hospital because "there was too much going on." The BF did not have concerns regarding the SM misusing substances. The BF declined bereavement referrals offered by ACS.

Neighbors present at the scene of the fatality were interviewed and stated they regularly heard screams coming from the apartment due to the SM and BF fighting. The neighbors stated the scream heard the day of the fatality was "different," and they went into the hallway to investigate, and found the SM holding the SC who was "purple and limp." A neighbor laid the SC down on a towel and performed CPR while another neighbor called 911. The SC was naked but did not appear wet, and "water and food came out of the SC while compressions were being done." Another neighbor stated the SC appeared grey and had no pulse. The neighbors stated the SSs were observed in the hallway during the incident, and the SM was on the floor screaming, "my baby is dead." Neighbors expressed concern regarding the SM using illegal substances; however, the case record does not reflect there were concerns of the SM being under the influence the day of the fatal incident.

While in the hospital, the 4yo SS made a statement to ACS about "the baby being in the water." ACS did not ask additional questions due to the scheduled forensic interview. LE attempted to conduct two forensic interviews which were unsuccessful due to the SSs age and a speech delay. There were no additional attempts to interview the 4yo SS documented in the case record.

ACS obtained information from a collateral contact who stated the SM told them she left the SC in the bathtub when she went to go pick up the SSs from daycare and go grocery shopping because "she [the SC] looked comfortable, and she was

having fun, and she didn't want to bother her." When the SM returned to the home, she found the SC unresponsive.

ACS conducted an emergency removal and filed an Article 10 Neglect petition in family court. The case remained open for services when the investigation closed.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
068359 - Deceased Child, Female, 11 Month(s)	069528 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
068359 - Deceased Child, Female, 11 Month(s)	069528 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
068359 - Deceased Child, Female, 11 Month(s)	069528 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
068359 - Deceased Child, Female, 11 Month(s)	069528 - Mother, Female, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
069529 - Sibling, Female, 4 Year(s)	069528 - Mother, Female, 30 Year(s)	Emotional Neglect	Substantiated
069529 - Sibling, Female, 4 Year(s)	069528 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
069529 - Sibling, Female, 4 Year(s)	069528 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
069529 - Sibling, Female, 4 Year(s)	069528 - Mother, Female, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
069530 - Sibling, Female, 2 Year(s)	069528 - Mother, Female, 30 Year(s)	Emotional Neglect	Substantiated
069530 - Sibling, Female, 2 Year(s)	069528 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
069530 - Sibling, Female, 2 Year(s)	069528 - Mother, Female, 30 Year(s)	Lacerations / Bruises / Welts	Substantiated

069530 - Sibling, Female, 2 Year(s)	069528 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
069530 - Sibling, Female, 2 Year(s)	069528 - Mother, Female, 30 Year(s)	Parents Drug / Alcohol Misuse	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

Overall, progress notes were entered timely; however, there were multiple notes that were entered more than 2 months after their corresponding event date.

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	☒	☐	☐	☐

Explain:
Appropriate services were offered to the caregivers in response to the fatality.

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:
An emergency removal was conducted in response to the fatality, and the SSs were placed with a kinship resource. On 8/16/24, an Article 10 Neglect petition was filed in Family Court against the SM.

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:**
08/16/2024	There was not a fact finding	There was not a disposition
Respondent:	069528 Mother Female 30 Year(s)	
Comments:	An Article 10 Neglect petition was filed in Family Court and an emergency removal of the SSs was conducted in response to the fatality; the SM was awarded supervised visitation.	

Have any Orders of Protection been issued? No

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☒	☐	☐	☐	☐	☐
Preventive Services	☒	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The surviving siblings received services while in foster care.

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

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)
06/08/2024	Deceased Child, Female, 9 Months	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 4 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 2 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 9 Months	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 9 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Sibling, Female, 4 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 4 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Female, 9 Months	Mother, Female, 30 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 30 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 2 Years	Father, Male, 41 Years	Lack of Supervision	Unsubstantiated

Report Summary:
On an ongoing basis, the SM and the BF engaged in physical altercations in the presence of the children, further details were unknown. During this time, the SM misused substances to impairment, rambling and slurring her words when impaired. On an unknown date, the SM and BF left the 4yo SS unsupervised in the home for an unknown period of time. On another date, the SM left the SC alone in a car for an unknown period of time. The SM was also alleged to have driven recklessly with the children in the car without car seats.

A duplicate report received on 7/18/24, that alleged the BF physically assaulted the SM in the presence of the children which resulted in the SM requiring emergency care.

Report Determination: Indicated	**Date of Determination:** 08/07/2024

Basis for Determination:
The BF was indicated for IG in regard to the SC and SS's. The investigation revealed that on 7/4/24, there was an argument between the BF and the SM that escalated to physical violence. As a result, the SM required emergency care after she sustained an injury. Allegations of LSUP and PD/AM were unsubstantiated due to a lack of evidence.

OCFS Review Results:
Despite the case record stating the 4yo SS was developmentally on target, there were no documented efforts to interview the child who was present during the incident. The 4yo SS's biological father was not added to the case, nor were attempted efforts to locate/engage him documented in the case record. This case practice issue was cited in an investigation from 2/16/22 and will not be cited again. ACS made referrals for appropriate consults.

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)
03/27/2024	Sibling, Female, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 2 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 6 Months	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	

Sibling, Female, 3 Years	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 2 Years	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 6 Months	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 3 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 2 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Female, 6 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
On an ongoing basis, the SM was under the influence of an illicit substance while acting as the sole caregiver of the children. The SM operated a motor vehicle while under the influence with the children present and used substances in the children's presence. Additional allegations included the BF physically assaulted the SM in the presence of the children because of the SM's substance use.

Report Determination: Unfounded | **Date of Determination:** 05/21/2024

Basis for Determination:
During the investigation it was revealed that one of the SM's old friends was making "frivolous reports against the family," and there was no evidence to substantiate the allegations.

OCFS Review Results:
ACS made adequate collateral contacts, provided the family with appropriate referrals, and obtained useful information regarding substance use. There was no documentation in the case record of ACS providing safe sleep education/information to the SM and BF. The RAP was incorrectly scored 'no' for history of domestic violence despite ACS obtaining DIR's for both caregivers. However, if scored correctly the risk rating would not change. There was no documentation in case record of the bio father of the then 3yo SS having been contacted, or any attempts to contact him. Additionally, there were no documented attempts to interview the then 3yo SS, despite the child being described as "developmentally on target" in the case record. Due to this case practice issue being cited in a previous case dated 2/16/22, it will not be cited again.

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

Issue:

Failure to provide safe sleep education/information

Summary:

Through the course of the investigation, there was no documentation that safe sleep education/or information was discussed or provided to the SM and BF.

Legal Reference:

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

Action:

ACS will provide information on Sleep Safety to the parents and caretakers of infants whom they encounter and see that the parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/14/2024	Sibling, Female, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 3 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 4 Months	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 4 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 40 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Father, Male, 40 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 4 Months	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 4 Months	Father, Male, 40 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
On an ongoing basis, the SM and BF engaged in verbal and physical altercations in the presence of the children and became impaired while acting as the sole caregivers.

Report Determination: Unfounded | **Date of Determination:** 03/08/2024

Basis for Determination:
During the investigation, it was discovered that the source of the report had been upset with the SM and "made a frivolous report against the family." The SM and BF denied the allegations of substance misuse and verbal/physical violence between them. The case was unfounded and closed.

OCFS Review Results:
ACS conducted thorough interviews; however, there was no documentation present in the case record of drug screen results being obtained, or that the BF was requested to submit to a drug screen. There were adequate safety assessments of the children; however, there was minimal documentation regarding the home. ACS accepted the parents' denial of domestic violence despite a previous ACS investigation with domestic violence allegations, and the SM having been arrested after she cut the BF's face. The case record does not reflect that the then 3yo SS's biological father was added to the report, contacted, or that efforts were made to engage him. This case practice issue was cited in an investigation from 2/16/22 and will not be cited again.

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)
11/18/2022	Sibling, Female, 2 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 2 Years	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 9 Months	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Months	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 2 Years	Mother, Female, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
The SM had a history of erratic and aggressive behavior in the presence of the children, which included breaking doors, televisions, and phones. On 11/17/22, the SM attempted to stab the BF in the presence of the children and caused a laceration on his chin. The children were not injured in the incident. On 11/15/22, the SM was acting in an aggressive manner and hit herself in the head with her fist and slammed her head into a wall in the presence of the children. Approximately 2 weeks prior, the SM became aggressive with the 2yo SS, which caused bruising.

Report Determination: Unfounded | **Date of Determination:** 01/25/2023

Basis for Determination:
The case was unfounded due to a lack of credible evidence. The SM and BF denied any previous incidents of domestic violence, and the BF reported it was unknown what the SM scratched his face with. A photograph was obtained of the scratch which revealed it to be approximately 2mm's in length. There were no marks or bruises observed on the children, and collateral contacts reported the fight was verbal only.

OCFS Review Results:
ACS made diligent efforts to obtain the whereabouts of the children to assess safety. The Safety Assessments and RAP were adequately scored. The biological father of the 4yo SS was not contacted and there was no documentation in case records of efforts made to engage him. The MGGM who resided in the home was not interviewed, nor was there documentation in case record of efforts to discuss the allegations with her. This practice issue was cited in an investigation dated 2/16/22 and will not be cited again. ACS documented in the case record that DIR's had been requested and there were none, despite the SM having been arrested.

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

Documentation showed ACS was allegation focused during interviews, primarily questioning the caregivers about domestic violence in the home. The SM and BF were not questioned about discipline, or allegations of the SM using physical discipline. Additionally, the SM was not questioned about current substance use, nor was the outpatient program contacted as a collateral.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

ACS will incorporate key safety-related questions as they pertain to case circumstances and will prioritize making an adequate assessment of safety and risk throughout the length of the investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/16/2022	Sibling, Female, 1 Hours	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes

Report Summary:
The SM gave birth to a baby girl who exhibited withdrawal symptoms and was in the NICU. The SM tested positive for illicit substances and had no plan for the newborn.

Report Determination: Indicated | **Date of Determination:** 04/02/2022

Basis for Determination:
ACS found a fair preponderance of evidence to indicate the SM for PD/AM. The SM failed to exercise the minimum degree of care when she engaged in substance use while pregnant resulting in the newborn experiencing withdrawal symptoms. The family was referred to, and accepted, Preventive services.

OCFS Review Results:
The investigation was completed and documented timely, and all aspects of safety were discussed. Adequate collateral contacts were made; however, the biological father of the 4yo SS was not contacted, nor were there documented efforts to contact him. There was no specific plan in regard to maintaining the safety of the children when the SM was administratively discharged from her inpatient program and returned home. There was no documentation in the case record that a notice of existence was provided to the MGGM, or that she was interviewed.

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:
ACS obtained the name of the biological father of the then 2yo SS; however, the case record did not reflect that ACS attempted to obtain contact details to discuss the open investigation with him, nor was he added to the case. Additionally, the MGGM, who lived in the home and was listed on the report, was not interviewed.

Legal Reference:
18 NYCRR 432.1 (o)

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
The safety plan was not accurately reflected in the Safety Assessments, nor was it adequately addressed with the parents. The original plan was for the SM to engage in inpatient substance use disorder treatment that would provide supervision to the mother and children; however, she was discharged unsuccessfully. There were no detailed actions or controlling interventions added to the Safety Plan to address the SM returning to the family home without successfully completing a substance use disorder program documented in the case record.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
The results of each safety assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

[redacted]

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 07/26/2024

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: 07/26/2024

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?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐

Additional information, if necessary:
A Preventive services case was opened following a domestic violence incident in which the father physically assaulted the subject mother in the presence of the children. This incident resulted in the subject mother requiring emergency medical services to treat a head injury. On 8/14/24, the SSs were removed and placed in foster care following the fatality of the SC.

Required Action(s)

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

Issue:	Failure to Complete a Plan Amendment

Summary:	A plan amendment was not completed following the fatality. The purpose of a plan amendment is to describe/document significant changes in the status of a case and direct a reassessment so that any necessary revisions to the service plan can be made.
Legal Reference:	18 NYCRR 428.7
Action:	ACS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Preventive Services History

On 2/17/22, a Preventive Services Case was opened for the family after the SM gave birth to the then 2yo SS. The SM tested positive for illicit substances and the 2yo SS experienced withdrawal symptoms. The SM engaged in substance use treatment, enrolled in mental health counseling, completed anger management, and Child-Parent Psychotherapy. The SC was born during the open case. There was an investigation in November 2022, which contained allegations of domestic violence in the home. The report was unfounded, and the case was closed. On 11/27/22, when all case objectives were met, the services case was closed.

On 7/26/24, a Preventive Services Case was opened following an incident of domestic violence in which the BF became physically violent with the SM, resulting in the SM requiring emergency medical treatment. An Article 10 Neglect petition was filed in family court, and an Order of Protection was issued between the BF, the SM and children. The children were released to the SM, and she agreed to follow family court recommendations. The fatality occurred during the open services case.

Required Action(s)

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

☒Yes ☐No

Issue:	Efforts must be made to involve birth parents, including birth fathers, in the development and review of the foster childs service plan
Summary:	There was no documentation in the case record that diligent efforts were made to involve the 4yo SS's father in planning for her permanency.
Legal Reference:	18 NYCRR430.12(c)(2)
Action:	ACS must make efforts to involve parents and guardians in the development of the service plan for any child in foster care whose permanency plan goal is to return to parent.

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

Child Fatality Report

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/26/2024	There was not a fact finding	There was not a disposition
Respondent:	069743 Father Male 41 Year(s)	
Comments:	An Article 10 Neglect petition was filed in Family Court against the BF following an incident of domestic violence in the home. The BF was physically violent against the mother in the presence of the children resulting in the SM requiring emergency medical care. A full Order of Protection was issued against the BF for the SM, SC, and SSs, and the children were released to the SM with orders that the family was to follow all Family Court recommendations.	

Have any Orders of Protection been issued? Yes	
From: 07/26/2024	**To:** 08/28/2024
Explain: An Order of Protection was issued after an incident of physical violence between the BF and the SM in the presence of the children which required the SM to obtain emergency medical care.	

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