Child Fatality Report

Report Identification Number: NY-24-097

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

Issue Date: Apr 15, 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: 4 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 10/14/2024
Initial Date OCFS Notified: 10/14/2024

Presenting Information

Multiple SCR reports were made between 10/13/24 and 10/15/24 regarding the fatal incident, death, and regarding information learned after the death. The reports made prior to the death, on 10/13/24, alleged the subject child (one report incorrectly named a sibling) was severely malnourished and underweight. The child had suspicious burn marks on his chest and the mother did not have an explanation for the marks or the child's condition. Sometime prior to 7:44PM on 10/13/24, the child became unresponsive and required emergency medical attention. The mother delayed seeking treatment for at least one hour. The child was laying in urine-soaked blankets and fecal matter for an unknown length of time. A third report was received on 10/14/24 following the child's death, with additional allegations that the three siblings had marks and bruises to various parts of their bodies and were also malnourished. A fourth report received on 10/15/24 further alleged the mother failed to provide adequate nutrition to the siblings, causing them to be underweight, malnourished, and they experienced medical issues as a result. Additionally, the siblings were unbathed, and their bodies and clothes covered in dirt.

Executive Summary

This report concerns the death of the 4-year-old subject child. The Administration for Children's Services (ACS) received multiple SCR reports regarding the child's condition and subsequent death (on 10/14/24), as well as concerns regarding the surviving siblings. At the time of the child's death, he resided with his mother, father, and siblings; ages 7, 6, and 5.

Throughout the day, on 10/13/24, the child had been feeling unwell and was throwing up, according to the mother. Sometime prior to 7:42PM, the mother notified the father upon his return home from the store that the child was unresponsive. It was unknown how long the child was unresponsive prior to the mother alerting the father. The father contacted 911, emergency medical services (EMS) arrived and began resuscitative measures. Law enforcement arrived shortly after. The mother and child were transported via ambulance to the hospital. Upon arrival, the child had no pulse and was in cardiac arrest. It took physicians ten minutes to revive the child. The child was described as "severely malnourished" and underweight, appearing "skin and bones." Scratch marks in varying shapes, sizes, and stages of healing were observed, and the child was very dirty and foul smelling. The child had a poor prognosis and was transferred to a second hospital for a higher level of care, where he was later pronounced deceased at 5:50AM on 10/14/24. The mother was arrested at the hospital and the father was arrested the following day.

The medical examiner was notified and performed an autopsy on the child. Although the autopsy was completed, the final autopsy report was not yet available at the time the CPS investigation was determined and closed. The medical examiner stated the manner of death would be homicide, "with some form of neglect;" however, the language to describe the neglect had not yet been worked out. The medical examiner expressed while the cause of death was pending, he believed "the child starved to death."

The family's home was deemed a crime scene and ACS was unable to complete a home visit. A description of the home was provided by the medical examiner, who completed a walk-through following the issuance of a search warrant. The home conditions were dismal, with a room full of feces, covered windows, and liquor bottles and marijuana containers throughout. The medical examiner summarized it as, "the children were living inside a cave in Manhattan." The siblings were promptly removed and brought to the hospital for evaluation, at which point they were admitted for further

evaluation and treatment. ACS initiated family court proceedings the following day.

ACS made the appropriate determination to indicate the report and substantiated the allegation of DOA/Fatality against both the mother and father, along with a multitude of additional allegations regarding not only the subject child, but the siblings as well.

At closing, both parents remained incarcerated and criminal proceedings were ongoing. The siblings were treated for malnourishment and once medically cleared for discharge from the hospital, they were placed together in a non-kinship medical foster home on 11/12/24. ACS continued their search for appropriate relative resources for the siblings. Due to the foster care placement and ongoing service needs of the family, a family services stage (FSS) was opened.

PIP Requirement

For citations identified in historical cases, 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) ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:

ACS made a determination of alleged allegations in congruence with available evidence. Given the ages of two siblings, the allegation of Educational Neglect could have been considered as well.

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:
An FSS was opened on 10/14/24 following the siblings' removal. The FSS remained open after the CPS investigation into the death was determined and closed.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/14/2024 **Time of Death:** 05:50 AM

Date of fatal incident, if different than date of death: 10/13/2024
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 07:42 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)

Deceased Child's Household	Sibling	Alleged Victim	Male	7 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Year(s)

LDSS Response

Between 10/13/24 and 10/15/24, ACS received multiple SCR reports regarding the subject child and siblings. ACS initiated their investigation immediately upon receipt of the first report and coordinated their efforts with law enforcement. ACS contacted the sources of the reports that availed themselves, completed a CPS history check regarding the family which revealed prior child welfare history with the agency, and informed the DA upon learning of the death of the subject child on 10/14/24. The safety of the siblings was assessed, and ACS executed an emergency removal of all three siblings on 10/14/24. The siblings remained in foster care throughout the CPS investigation and a corresponding FSS was opened.

Interviews with the parents were complicated by their arrests. A description of the fatal incident was obtained mostly via collateral contacts with first responding agencies. According to hospital staff, the mother reported the child had been vomiting and had diarrhea all day, and the mother believed the child got access to a bottle of Smirnoff Ice and drank it. Toxicology reports completed at autopsy revealed the child was negative for all substances. It was also reported to law enforcement by the mother that the child ate something bad from the refrigerator, causing him to vomit prior to becoming unresponsive on the evening of 10/13/24. The mother described the child had recently begun losing weight and she felt the child may have been sick. The mother went on to state she fed her children, and just a few days ago provided eggs and bacon, though specifics of when that occurred were not provided. At the time the child became unresponsive, the mother reported the father and siblings were not home but was unable to provide any verifiable information regarding the siblings' whereabouts. The mother reported at one point, the father stepped out of the home, and when he returned, he asked if everything was fine, which was when she informed him the child was unresponsive. The father then called 911. The emergency call was made at about 7:42PM. According to body camera footage observed by ACS, the mother reported around 6:30-6:45PM, the child was fine, and his change was recent. The father's account indicated the siblings were home at the time of the fatal incident, contradicting the mother. The father stepped out to go to the store and when he returned the mother told him the child was unresponsive. After EMS took the child, the father left the home with the siblings and brought them to a family member's home, where he left them.

ACS interviewed all relatives known to the agency. The paternal grandmother was called by the father on 10/13/24 and told the child was on the way to the hospital. ACS learned the father brought the siblings to a paternal great aunt's home. That aunt reported the children were dropped off about 9:30PM on 10/13/24, appearing thin and malnourished and with an odor. Maternal and paternal relatives were asked about recent contact with the family, and all reported no recent in-person contact, with mostly virtual contact. Family members reported providing money and food at times, though none reported overt concerns regarding the care of the children.

At the time of removal, 10/14/24, all siblings presented with protruding stomachs, body odor, and appeared unbathed as evidenced by being able to physically wipe dirt from their bodies. ACS brought the children to the hospital for medical care, where they were found with multiple medical concerns. They were severely underweight for their given ages and admitted for further evaluation and treatment. Due to malnutrition, the siblings had to be reintroduced to solid foods. The siblings were hospitalized consistently until 11/12/24, at which point they were discharged with a multitude of follow-up services to a foster home. Transitional meetings were held to ensure the foster parent knew of the siblings' needs.

ACS spoke with the ME, who expressed the child's condition was a clear picture of chronic malnourishment and neglect. At death, the 4yo child weighed only 19lbs. The child had almost no body fat, his organs had minimal fat tissue, and due to the lack of body fat, his body could not produce heat nor did the child have enough energy to create heat; his body

temperature was 80F. Hospital staff responding to the fatal incident described the child as “skin and bones.” The child was described as exceptionally thin, with no muscle, no fat, no pulse, and a core temperature incompatible with life. When asked how long it would take a child to die from starvation, hospital staff expressed, “this doesn’t happen overnight.”

ACS learned of the home’s condition through collateral contact with law enforcement and the ME. Law enforcement described the home as deplorable, extremely dirty, and with a foul odor. One bedroom was inaccessible as the door would not open due to a thick coat of what appeared to be feces on the floor. The ME posited the children were kept in that one room. The room was full of excrement, including feces smeared on the wall up to the height of a child. The windows were covered in dark curtains and there was one queen-sized mattress. The refrigerator was turned in such a way it was inaccessible. There was “not a lot but some” food observed in the home. There were empty liquor bottles, marijuana containers and baggies throughout, and a hole where mice were observed coming in and out. ACS requested photos taken of the scene, but they were not provided prior to case closure.

Both parents remained incarcerated, and the siblings remained in foster care, where they were receiving necessary services to address their medical, developmental, social, and educational needs. Criminal court and family court proceedings were ongoing. ACS found evidence to support many of the allegations contained in the multiple reports and appropriately indicated the investigation.

Official Manner and Cause of Death

Official Manner: Homicide
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: There is no Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069360 - Deceased Child, Male, 4 Year(s)	069361 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069362 - Father, Male, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069362 - Father, Male, 25 Year(s)	Lack of Medical Care	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069362 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069362 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

069360 - Deceased Child, Male, 4 Year(s)	069362 - Father, Male, 25 Year(s)	Burns / Scalding	Unsubstantiated
069360 - Deceased Child, Male, 4 Year(s)	069362 - Father, Male, 25 Year(s)	Malnutrition / Failure to Thrive	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069361 - Mother, Female, 26 Year(s)	Malnutrition / Failure to Thrive	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069361 - Mother, Female, 26 Year(s)	Lack of Medical Care	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069361 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069361 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069360 - Deceased Child, Male, 4 Year(s)	069361 - Mother, Female, 26 Year(s)	Burns / Scalding	Unsubstantiated
069360 - Deceased Child, Male, 4 Year(s)	069362 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
069363 - Sibling, Male, 7 Year(s)	069361 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069363 - Sibling, Male, 7 Year(s)	069362 - Father, Male, 25 Year(s)	Lack of Medical Care	Substantiated
069363 - Sibling, Male, 7 Year(s)	069362 - Father, Male, 25 Year(s)	Lacerations / Bruises / Welts	Substantiated
069363 - Sibling, Male, 7 Year(s)	069362 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069363 - Sibling, Male, 7 Year(s)	069362 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069363 - Sibling, Male, 7 Year(s)	069361 - Mother, Female, 26 Year(s)	Malnutrition / Failure to Thrive	Substantiated
069363 - Sibling, Male, 7 Year(s)	069361 - Mother, Female, 26 Year(s)	Lack of Medical Care	Substantiated
069363 - Sibling, Male, 7 Year(s)	069361 - Mother, Female, 26 Year(s)	Lacerations / Bruises / Welts	Substantiated
069363 - Sibling, Male, 7 Year(s)	069361 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
069363 - Sibling, Male, 7 Year(s)	069362 - Father, Male, 25 Year(s)	Malnutrition / Failure to Thrive	Substantiated
069363 - Sibling, Male, 7 Year(s)	069362 - Father, Male, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
069364 - Sibling, Male, 6 Year(s)	069361 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069364 - Sibling, Male, 6 Year(s)	069361 - Mother, Female, 26 Year(s)	Burns / Scalding	Unsubstantiated

069364 - Sibling, Male, 6 Year(s)	069362 - Father, Male, 25 Year(s)	Malnutrition / Failure to Thrive	Substantiated
069364 - Sibling, Male, 6 Year(s)	069362 - Father, Male, 25 Year(s)	Lack of Medical Care	Substantiated
069364 - Sibling, Male, 6 Year(s)	069362 - Father, Male, 25 Year(s)	Lacerations / Bruises / Welts	Substantiated
069364 - Sibling, Male, 6 Year(s)	069362 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069364 - Sibling, Male, 6 Year(s)	069362 - Father, Male, 25 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
069364 - Sibling, Male, 6 Year(s)	069361 - Mother, Female, 26 Year(s)	Malnutrition / Failure to Thrive	Substantiated
069364 - Sibling, Male, 6 Year(s)	069361 - Mother, Female, 26 Year(s)	Lack of Medical Care	Substantiated
069364 - Sibling, Male, 6 Year(s)	069361 - Mother, Female, 26 Year(s)	Lacerations / Bruises / Welts	Substantiated
069364 - Sibling, Male, 6 Year(s)	069361 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
069364 - Sibling, Male, 6 Year(s)	069362 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069365 - Sibling, Female, 5 Year(s)	069362 - Father, Male, 25 Year(s)	Malnutrition / Failure to Thrive	Substantiated
069365 - Sibling, Female, 5 Year(s)	069362 - Father, Male, 25 Year(s)	Lack of Medical Care	Substantiated
069365 - Sibling, Female, 5 Year(s)	069362 - Father, Male, 25 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
069365 - Sibling, Female, 5 Year(s)	069362 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
069365 - Sibling, Female, 5 Year(s)	069362 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069365 - Sibling, Female, 5 Year(s)	069361 - Mother, Female, 26 Year(s)	Malnutrition / Failure to Thrive	Substantiated
069365 - Sibling, Female, 5 Year(s)	069361 - Mother, Female, 26 Year(s)	Lack of Medical Care	Substantiated
069365 - Sibling, Female, 5 Year(s)	069361 - Mother, Female, 26 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
069365 - Sibling, Female, 5 Year(s)	069361 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
069365 - Sibling, Female, 5 Year(s)	069361 - Mother, Female, 26 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
069365 - Sibling, Female, 5 Year(s)	069362 - Father, Male, 25 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?	☐	☒	☐	☐
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:

No pediatric physician records were requested; however, it was unclear if the children had primary care physicians established prior to the fatality. Not all first responders, specifically EMS, were contacted. The subject parents were unable to be fully interviewed due to their legal status. None of the children had ever been enrolled in school; therefore, there were no educational collaterals with information on the family prior to the fatality. The siblings were essentially nonverbal and unable to be interviewed.

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:
The siblings required protection through foster care. ACS ensured the siblings had access to required medical care, and at closing, the contract agency responsible for the oversight of the foster care case, in conjunction with ACS ensured ongoing medical services and educational services were provided to the siblings. The status of available services to the incarcerated parents was unknown; however, they would be included in case management services as part of the FSS.

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:
All three siblings were removed as a result of information uncovered during the fatality investigation. ACS executed an emergency removal of the siblings on 10/14/24 and the removal was upheld in family court the following day, 10/15/24, upon the filing of Article 10 petitions.

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:**
10/15/2024	There was not a fact finding	There was not a disposition
Respondent:	069361 Mother Female 26 Year(s)	
Comments:	ACS filed Article 10 petitions in family court on behalf of the children. The siblings were placed into the care/custody of ACS and were hospitalized due to medical concerns related to malnutrition. Once medically cleared, on 11/12/24, the siblings were placed in a non-kinship foster home. Orders of Protection were issued on behalf of the siblings and family court proceedings remained ongoing.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
10/15/2024	There was not a fact finding	There was not a disposition
Respondent:	069362 Father Male 25 Year(s)	
Comments:	ACS filed Article 10 petitions in family court on behalf of the children. The siblings were placed into the care/custody of ACS and were hospitalized due to medical concerns related to malnutrition. Once medically cleared, on 11/12/24, the siblings were placed in a non-kinship foster home. Orders of Protection were issued on behalf of the siblings and family court proceedings remained ongoing.	

Criminal Charge: Assault **Degree:** 1			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
10/14/2024	Mother and Father	Pending	Pending
Comments:	The parents were charged with four counts of Assault, specifically under circumstances evincing a depraved indifference to human life by recklessly engaging in conduct that created a grave risk of death to another person.		

Criminal Charge: Murder **Degree:** 2

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
10/14/2024	Mother and Father	Pending	Pending
Comments:	The parents were charged with Murder in the Second Degree. Specifically, with depraved indifference to human life by recklessly engaging in conduct which created a grave risk of serious physical injury or death to another person less than eleven years old, and thereby caused the death of such person.		

Criminal Charge: Manslaughter **Degree:** 2

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
10/14/2024	Mother and Father	Pending	Pending
Comments:	The parents were charged with Manslaughter in the Second Degree for recklessly causing the death of another person.		

Criminal Charge: Criminally negligent homicide **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
10/14/2024	Mother and Father	Pending	Pending
Comments:	The parents were charged with Criminally Negligent Homicide.		

Criminal Charge: Endangering the welfare of a child **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
10/14/2024	Mother and Father	Pending	Pending
Comments:	The parents were charged with four counts of Endangering the Welfare of a Child.		

Have any Orders of Protection been issued? Yes

From: 10/15/2024	**To:** Unknown

Explain:
Family court issued full Stay Away Orders of Protection against both parents on behalf of the siblings barring any contact with the siblings, other than ACS-approved contact.

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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The mother received counseling services while incarcerated, though the level of engagement was unknown. It was unknown what services the father was receiving while incarcerated. ACS continued diligent efforts to explore relative resources throughout the CPS investigation, and casework activity continued into the ongoing FSS. The siblings received foster care services. After receiving extensive medical care, they were discharged from the hospital to a non-kinship medical foster home where their service needs would continue to be monitored in the FSS. While family planning and parenting skills would be beneficial to both parents, given their legal status, those services would likely be unable to be implemented at this time.

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 siblings received psychosocial support while hospitalized. Upon discharge to foster care, the siblings were referred to physical therapy, speech/language pathology, occupational therapy, and had service goals that included individual therapy, education referrals, and ongoing medical follow-up.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes

Explain:

Both parents remained incarcerated. The mother indicated she had access to counseling services, though did not find it helpful. The father had recently changed facilities and was not engaged in services at the time the fatality investigation closed. Both parents were listed on the ongoing FSS with service goals of bereavement counseling, individual therapy, and monthly virtual case planning meetings.

History Prior to the Fatality

Child Information

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

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/21/2022	Deceased Child, Male, 2 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Father, Male, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 2 Years	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Father, Male, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 5 Years	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:

An SCR report was received on 7/21/22 which alleged the apartment in which the mother, father, and children resided was a health hazard. The apartment was infested with rats and some of the rats were dead. There was also a very strong foul odor coming from the apartment. Additionally, on an unknown date, the father physically assaulted the mother in the presence of the children. Only the subject child and one sibling were listed in the SCR report.

Report Determination: Unfounded

Date of Determination: 09/19/2022

Basis for Determination:
ACS concluded the mother complied with directives to have the children medically seen and worked with ACS to "get the rat and flies" out of the home. ACS assessed that the father was "a protector" and that he was nervous the family would be broken apart with ACS involvement; however, he worked with ACS to address the hole in the wall. Additionally, the mother asked for help getting the children in school. The family was assessed to have adequate food and clothing. ACS summarized the apartment was not deplorable, and the building had a rat and fly infestation, to which ACS assisted with connecting the family to the appropriate resources.

OCFS Review Results:
Although the parents were difficult to engage and refused access to the home except on one occasion, there were missed opportunities to assist the family. The family historically demonstrated difficulty keeping a clean home, and this investigation was closed without a mechanism in place to monitor the eradication of the infestations or ensure the hole in the wall was closed. Although an Early Intervention referral was made, the three siblings were age eligible for Committee on Preschool Special Education (CPSE) evaluations, which the mother was not assisted with requesting despite supervisory directives, the mother requesting assistance with school enrollment, and this being an ongoing concern in multiple historical cases. The eldest sibling was eligible to be enrolled in kindergarten. While not yet of compulsory age, ACS could have assisted. While the mother refused to sign a HIPAA consent, she did provide discharge summaries from the requested medical assessments. While these assessments of the children were appropriately completed on 8/11/22 and 8/12/22, the medical provider indicated follow up appointments were needed on or around 8/15/22. These were not confirmed prior to case closure. Although ACS determined the family was assessed to have an adequate food supply, there were no progress notes documenting an assessment of food supply.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
There were outstanding collateral contacts/casework activities that should have been completed to ensure the family's needs were addressed, such as, assisting the mother with school enrollment and applicable educational evaluations, ensuring follow-up medical appointments were attended, and ensuring the hole in the wall was closed prior to case closure.

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

Action:
ACS will review and adhere to regulations regarding casework practice. ACS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

Issue:
Adequacy of Progress Notes

Summary:
Supervisory and summary notes entered into CONNECTIONS reflected casework activity had occurred that had not been adequately documented into progress notes. A supervisory note dated 9/6/22 stated the kitchen and living room had been observed, though no progress notes reflected that had happened prior to that date. That same note reflected a home visit had occurred with the building superintendent; however, there was no progress note regarding a home visit with the superintendent documented until 9/14/22. There was no corresponding progress note regarding assessing food in the home, though the 9/6/22 supervisory note reflected an adequate supply. The record reflected the mother was "guided" to follow up on Committee on Preschool Special Education (CPSE) concerns, but no progress note documented the mother was provided that assistance.

Legal Reference:

18 NYCRR 428.5

Action:

ACS will accurately document all casework activity into progress notes.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP was scored that no child had been in the care/custody of a substitute caregiver; however, the subject child resided with a paternal aunt immediately following birth for an unknown length of time due to the parents being unable/unwilling to provide parenting responsibility at that time.

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.

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

3/15/19 – 5/14/19 The allegation of Inadequate Guardianship was substantiated against the mother for the siblings. Although the parents denied physical interpersonal violence, there were times law enforcement was called to intervene as the parents were engaged in physical altercations with one another. The family resided in a shelter at the time and received a Pack 'N Play along with diapers and formula from ACS. Additionally, a services referral was accepted and an FSS was opened as a result.

12/4/19 – 1/31/20 The allegation of Inadequate Guardianship was unsubstantiated against the father regarding the siblings. It was alleged the father physically assaulted the mother in the presence of the siblings; however, the mother reported the father was not present when she sustained bruising. The family's service provider was contacted and reported no concerns regarding the care of the siblings or incidents of altercations. Again, the family received a Pack 'N Play, diapers, wipes, along with cleaning products and toiletries from ACS. Immunization records showed the siblings were up-to-date and ACS requested Early Intervention (EI) referrals on behalf of the siblings. The FSS remained open.

1/31/20 – 2/6/20 The allegations of Inadequate Guardianship and Parent's Drug Alcohol Misuse were unsubstantiated against the mother regarding the subject child. The mother had a positive toxicology, but the child tested negative at birth. A home visit was completed, and the home was observed with adequate provisions such as a crib, diapers, baby clothing, and other necessities. The child was being provided pumped breast milk. Shelter staff voiced no concerns. A daycare voucher was provided, and the mother reported an upcoming WIC appointment. ACS again documented making EI referrals on behalf of the children. The FSS remained open.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

5/14/19 – 7/15/20 An FSS was opened following an indicated CPS investigation and services were provided by a contract agency. At opening, the parents reported feeling stressed due to their living conditions. They reported selling items to buy

the children clothing and diapers, and reported no support from family. Household management, budgeting, and exploring a support system were never addressed. It was documented ACS provided the mother daycare vouchers and referred all three siblings to Early Intervention (EI). Despite the eldest sibling having a notable speech delay, none of the siblings had received EI evaluations, nor were any attempts documented to assist the family in accessing EI services. While many daycare facilities shut down in spring 2020 due to COVID-19, no attempts were made to facilitate finding a provider prior to that time, despite the family's difficulty in doing so on their own. The family remained minimally engaged throughout the open case, often needing reminders and missing home visits. The subject child was born during the case, on 1/31/20, and the family planned for him to reside with a paternal aunt. The child remained informally with that aunt through the remainder of the case with no discussion with the family on a reunification plan. The parents repeatedly voiced feeling overwhelmed with the responsibilities of caring for the multiple young children, yet the services goal remained focused on the reason for case opening rather than to the changing needs of the family. On numerous occasions, concern for the cleanliness of the family's shelter unit was documented, but the family was never engaged in a discussion the concerns of excess clutter posed to young children, nor was the repeatedly documented odor ever addressed with the family. The family demonstrated a lack of motivation for change and struggled to complete concrete tasks, and while casework contacts were made with regularity, the agency did not provide hands-on assistance to the family to complete tasks; therefore, tasks took many months to complete (like re-establishing a benefits case) or were not completed at all (like daycare enrollment or EI evaluations). It was not documented that the children's medical providers were spoken to; therefore, it remained unknown if regular preventive care was practiced. It was unclear what progress the family made that warranted case closure. Due to the COVID-19 pandemic the family had limited engagement with outside services upon the case closing in July 2020.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

Action:	At times, vulnerable New Yorkers are involved with a confluence of systems outside child welfare. The Office of Temporary and Disability Assistance (OTDA) is one such agency involved in supervising programs that provide assistance and support to families and individuals, specifically cash and food assistance. In respect to the subject family of this fatality report, there were two school-aged siblings receiving such assistance. Currently, school attendance for all minors (except as specifically outlined for ages 16-18) is not a condition of eligibility for Temporary Assistance (nor SNAP or Medicaid). To bring practice into line with cited values of OTDA (that OTDA strongly encourages school attendance for all minor children and believes that education is one of the most effective ways to end the cycle of poverty and achieving self-sufficiency (06-INF-12 Revised)) and the State Education Department's compulsory attendance requirement that children ages 6-16 be provided with a program of instruction, it is suggested OTDA's requirements for school attendance verification be extended to all compulsory aged children included on an application for assistance. Family assistance shall not be denied to children based on enrollment status if otherwise determined to be eligible. Where there is concern a child's enrollment status appears to violate the State Education Department's mandates, a referral shall be made to children's services for further assessment.

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