Child Fatality Report

Report Identification Number: SV-25-014

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

Issue Date: Jul 21, 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: 6 month(s)
Jurisdiction: Nassau
Gender: Female
Date of Death: 04/09/2025
Initial Date OCFS Notified: 04/09/2025

Presenting Information

Nassau County Department of Social Services (NCDSS) completed an OCFS-7065 Agency Reporting Form on 4/10/25, after learning of the subject child's death. There was an open preventive services case at the time of the death due to NCDSS filing an Article 10 neglect petition against the mother because of her inability to care for the subject child due to her alcohol misuse.

Executive Summary

This fatality report concerns the death of the 6-month-old subject child that occurred on 4/9/25. The fatality occurred while there was an open preventive services case, initiated on 12/4/24. The subject child was born prematurely, at 25 weeks, as a result of the mother's alcohol misuse, and the subject child required intensive care for the entirety of her life. When the preventive service case was initially opened, the 15-year-old surviving sibling was residing with his father out-of-state; however, during the open case the mother brought the surviving sibling to reside in New York.

The subject child was born with multiple and severe medical conditions, was never able to breathe on her own and utilized a ventilator. During her time spent in the hospital, the subject child underwent several surgeries including a procedure for a gastrostomy tube for eating. The subject child remained hospitalized until her death.

NCDSS did not document contact with hospital staff after the subject child's death. It was unclear if an autopsy was performed or if the death was referred to a medical examiner or coroner. There was no documentation of any law enforcement involvement. The cause of death was reported by the mother to be bronchopulmonary dysplasia, also known as chronic lung disease.

NCDSS noted that the hospital provided the mother with bereavement resources. It did not appear that NCDSS provided bereavement resources to the mother, father or surviving sibling. There was no documentation of NCDSS offering the family burial assistance.

PIP Requirement

NCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the NCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, NCDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**

- **Safety assessment due at the time of determination?** N/A

Determination:

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

Explain:
There was no SCR report with DOA/Fatality allegations regarding the SC.

Was the decision to close the case appropriate? Unknown

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:
It was unclear if it was appropriate for the case to close due to NCDSS never assessing the SS for safety and risk, before or after the SC died. After the SC's death, NCDSS did not document contacting medical staff to confirm the details surrounding the child's death. The BF was listed on the preventive case; however, it did not appear NCDSS engaged with him.

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: 04/09/2025 **Time of Death:** 07:30 AM (Approximate)

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

County where fatality incident occurred: Nassau
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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: Hospitalized

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	6 Month(s)
Other Household 1	Mother	No Role	Female	32 Year(s)
Other Household 2	Father	No Role	Male	31 Year(s)
Other Household 3	Sibling	No Role	Male	15 Year(s)
Other Household 4	Other Adult - SS's BF	No Role	Male	33 Year(s)

LDSS Response

There was an open preventive services case at the time of the subject child's death, and NCDSS was informed of the death by the mother. During her 6 months of life, the subject child never left the hospital. The mother was residing in DSS assisted housing and the father at his own respective residence.

During the open preventive case, the mother retrieved the 15-year-old surviving sibling from his father's home, out-of-state, and brought him to New York to reside with her; however, the surviving sibling was unable to stay in assisted housing with the mother. The mother reported she sent the surviving sibling to stay with the subject child's father and then her sister. The surviving sibling was not seen or assessed to be safe by NCDSS before or after the subject child's death.

The subject child was born with multiple and severe medical conditions, was never able to breathe on her own and utilized a ventilator. During her time spent in the hospital, the subject child underwent several surgeries. The subject child was able to move from the neonatal intensive care unit to the pediatric intensive care unit. There was discussion of transferring the subject child to an out of state hospital that specialized in premature chronic lung disease; however, the subject child was never stable enough for transfer. The mother reported that on 4/9/24, the subject child passed away due to bronchopulmonary dysplasia. NCDSS did not document confirming the cause of death with medical staff.

The mother reported drinking alcohol three times a week during her pregnancy and during her pregnancy, she was hospitalized due to her alcohol misuse. She reported an extensive history of alcohol misuse that "spiraled" in 2020. The mother explained that during her pregnancy she was a victim of domestic violence with her ex-partner, including an incident the day prior to going into premature labor.

After the subject child died, the mother stated she no longer wanted a preventive services case opened. NCDSS reported the subject child's death to Nassau County Family Court and the mother's court orders of supervision were terminated. NCDSS did not document assessing if it was appropriate to close the case based on the surviving sibling. The mother reported the surviving sibling was having behavioral and mental health concerns and the mother moved the surviving sibling to New York; however, it is unclear if the behavior problems and suicidal ideations were addressed and if the surviving sibling was ever enrolled in school or mental health counseling in New York.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: NCDSS has an OCFS-approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

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

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☐	☒	☐	☐
At 30 days?	☐	☒	☐	☐

Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Explain:
There was no SCR report with allegations of DOA/Fatality regarding the SC; therefore, no official Safety Assessments were required to be completed; however, after the SC's death NCDSS did not adequately assess the SS for impending or immediate danger.

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:
There was no SCR report with allegations of DOA/Fatality regarding the SC; therefore, no official Risk Assessment was required to be completed; however, after the SC's death NCDSS did not adequately assess the risk factors pertaining to the SS. Appropriate services were offered and provided to the mother regarding her alcohol misuse and MH needs; however, it was unclear if further services or interventions were required regarding the SS.

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?	☐	☒	☐	☐

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:
11/26/2024	There was not a fact finding	Order of Supervision
Respondent:	071294 Mother Female 32 Year(s)	
Comments:	NCDSS filed an Article 10 neglect petition against the mother after she gave birth to the subject child due to her alcohol misuse. The mother consented to a finding of neglect and a year of supervision with NCDSS. The terms of supervision included her completing substance abuse treatment. The order of supervision was terminated after the subject child's death.	

Have any Orders of Protection been issued? Yes

From: Unknown	**To:** 12/02/2025

Explain:
NCDSS filed an Article 10 neglect petition against the mother after she gave birth, and an order of protection was issued in favor of the subject child, stating that the mother would stay away from the subject child when she was under the influence. The order of protection included general refrain from orders.

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:
NCDSS documented that hospital staff provided the mother with bereavement resources; however, there was no documentation of NCDSS providing bereavement resources to the BF or SS. The mother was in treatment for her alcohol misuse and also receiving MH counseling in the program. There was a history of DV between BM and her ex-girlfriend and the BF; however, no DV services were offered.

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? No
Explain:
NCDSS did not provide bereavement services to the family for the SS.

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? No
Explain:
NCDSS documented that the mother was provided with bereavement resources from hospital staff; however, there was no documentation of the BF being provided with bereavement resources.

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? Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/27/2024	Deceased Child, Female, 1 Days	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
An SCR report was received that alleged the mother delivered the SC premature at 25 weeks. The SC weighed 1lb. There were concerns for the safety of the SC after being discharged due to the mother's alcohol misuse and DV. The mother was not in an alcohol treatment program. The BF had a history of physical violence toward the mother. The mother had another child that was not in her care.

Report Determination: Indicated | **Date of Determination:** 12/05/2024

Basis for Determination:
NCDSS substantiated the allegation of IG against the mother regarding the SC. On 9/27/24, the mother gave birth to the SC prematurely, at 25 weeks. The mother had a significant history of alcohol misuse and drank alcohol throughout her pregnancy, including the day before giving birth. The mother was admitted to a psychiatric unit that same year and while admitted, consumed alcohol and had positive screens. The mother had a significant history with LE regarding her alcohol misuse. NCDSS filed an Article 10 neglect petition in Nassau County Family Court.

OCFS Review Results:
NCDSS began their investigation immediately, contacted the source, and completed a CPS history review. NCDSS remained in contact with the mother, her substance abuse provider, and hospital staff. NCDSS spoke with the mother's MH counselor, care coordinator and received LE records. NCDSS filed an Article 10 neglect petition against the mother. The allegations were addressed with the BF and his home was assessed; however, NCDSS did not explore risk questions with the BF. NCDSS did not discuss safe sleep education with either parent. Although hospital staff went over a plan of safe care with the BM, NCDSS did not. The subject child remained hospitalized.

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)

05/04/2022	Sibling, Male, 12 Years	Other Adult - SS's BF, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 12 Years	Other Adult - SS's BF, Male, 33 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 12 Years	Other Adult - SS's BF, Male, 33 Years	Other	Unsubstantiated	

Report Summary:
An SCR report was received that alleged the SS's BF was physically abusive towards the SS. The SS's BF would frequently punch the SS when he was in trouble. As a result, the SS would sustain bruises on his stomach, legs and arms. A month prior to the SCR report, the SS's BF threw the SS into a table, causing the glass to break. The SS had 3-4 scars on his upper left arm as a result. On 5/3/22, as a form of punishment for getting lunch detention, the SS's BF had the SS go on a pull up bar for two hours and do a plank for one hour. The SS's BF would curse and yell at the SS if he fell. As a result, the SS had pain in his neck and pain when he would get up from a seated position.

Report Determination: Unfounded | **Date of Determination:** 08/04/2022

Basis for Determination:
NCDSS unsubstantiated the allegations of IG, L/W/B and XCP due to a lack of a fair preponderance of evidence. The SS's great-aunt and father denied the allegations. The SS's BF reported he did make the SS do pull-ups and planks and that the SS was an athlete and worked out on a daily basis. The SS's BF reported he normally disciplined the SS by taking away his cell phone or bike. The SS reported his father had him do the pull-up bar and planks as punishment for school misbehavior. The SS denied being thrown or falling onto a glass table. The SS was checked for marks and bruises, and none were observed. The SS's BF was advised against excessive corporal punishment.

OCFS Review Results:
NCDSS immediately began their investigation by assessing the SS to be safe and free from any marks or bruises. They contacted the source and completed a CPS history review; although, not until the case had been open for over two months. It was unclear if one of the family members was the SS's aunt or uncle as it was documented differently in several places. NCDSS spoke with all the family members regarding the allegations; however, did not interview the mother, the SS, or the SS's aunt/uncle regarding risk-related questions; therefore, it was unclear how NCDSS was able to answer the RAP questions. NCDSS did not contact all appropriate collaterals.

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

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

Summary:
NCDSS spoke with the mother, SS, and OA in the home about the allegations; however, did not ask risk-related questions to assess ongoing safety and risk factors.

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

Action:
NCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.

Issue:
Review of CPS History

Summary:
A CPS history check was completed untimely. The SCR report was received on 5/4/22; however, the history check was completed on 7/27/25.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

Within one business day, NCDSS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

Despite concerns for the SS in school, NCDSS did not follow up with the school after the initial contact the day the investigation began, to determine if the concerns continued. NCDSS did not request the SS's attendance, grades, or discipline records. Despite the concerns for physical abuse NCDSS did not speak with the SS's primary care provider or request LE records.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

NCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

It was unclear how NCDSS was able to appropriately answer the Risk Assessment questions when no risk related questions were asked to the mother, SS or another adult in the home.

Legal Reference:

18 NYCRR 432.2(d)

Action:

NCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

[redacted]

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

An investigation was opened from 10/16/20-2/26/21, with an allegation against the mother being unsubstantiated for IG regarding another child.

An investigation was opened from 2/28/19-6/8/19, with allegations against the mother being unsubstantiated for IG and EdN regarding the SS.

An investigation was opened from 4/30/18-6/13/18, with allegations of IG, PD/AM, and OTH/COI being unsubstantiated regarding the SS and the mother's sister.

A FAR case was opened from 9/23/16-3/31/17, with allegations of CD/A and IG against the mother regarding the SS.

An investigation was opened from 4/28/16-5/14/16, with an allegation of IG being substantiated against the SS's BF regarding the SS.

An investigation was opened from 3/15/16-3/28/16, with allegations of IG and IF/C/S being unsubstantiated against the SS's BF regarding the SS.

An investigation was opened from 10/20/15-12/26/15, with an allegation of IG being substantiated and an allegation of PD/AM being unsubstantiated against the SS's BF regarding the SS and with allegations of IG and PD/AM being unsubstantiated against the mother regarding the SS.

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: 12/04/2024

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?	☐	☒	☐	☐

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:
Appropriate services were provided to the mother pertaining to her alcohol misuse, and MH; however, she was not offered DV resources. There was no documentation of NCDSS assessing the BF or SS for services needs and it is unclear if their needs went unmet. The BF was listed on the case; however, was not seen face-to-face as required.

Required Action(s)

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

Issue:	Adequacy of services following the fatality
Summary:	NCDSS did not appear to offer the family burial assistance. The BF and SS were never contacted following the fatality, in an effort to explore potential service needs and no bereavement services were provided to them.
Legal Reference:	18 NYCRR 432.2(b)(4);428.6
Action:	NCDSS will explore areas of potential service needs with all family members with whom they are involved. NCDSS will appropriately respond to changing circumstances, and if service needs are identified, NCDSS will make the appropriate referral to preventive or community-based services in an effort to determine whether there are services that can benefit the family.

Issue:	Adequacy of case recording in FASP
Summary:	The BF was seen twice between 12/11/24 and 5/15/25, and there were no documented conversations with him, specifically pertaining to his ability to care for the SC upon her release from the hospital. Safety and risk factors were not explored.
Legal Reference:	18 NYCRR 428.6(a)

Action:	NCDSS will record information gathered about the family in receipt of child welfare services, including preventive, child protective, foster care and/or adoption services; assist with evaluations/assessments, assist with determining the family's need for services to achieve permanency planning goal; assist with ascertaining family progress in meeting desired outcomes and with ongoing planning.

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

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: An order of protection was issued in favor of the mother, protecting her from her ex-girlfriend, who assaulted her during her pregnancy.	

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