Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-24-108

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

Issue Date: May 20, 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: 2 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 11/26/2024
Initial Date OCFS Notified: 11/26/2024

Presenting Information

The SCR report alleged that on 11/26/24, the godmother was caring for the subject child. At approximately 7:00 PM, the godmother placed the subject child face down on a bed for a nap. The godmother then lay down and took a nap beside the subject child. Sometime before 7:55 PM, the godmother woke up and found the subject child not breathing. Another adult began cardiopulmonary resuscitation, and 911 was called. First responders arrived at the home at an unknown time and performed cardiopulmonary resuscitation on the subject child. The subject child was transported to the hospital and pronounced deceased at 9:03 PM. The SCR report alleged that the unsafe sleeping arrangement contributed to the subject child's death.

Executive Summary

This fatality report concerns the death of the 2-month-old female subject child that occurred on 11/26/24. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the subject child's godmother. At the time of her death, the subject child resided with her mother and two siblings, ages 4 and 2. The alleged father of the subject child resided in a separate residence and had another infant child. The godmother resided with her mother. The godmother's 7-year-old child resided with her father.

The Administration for Children's Services (ACS) completed casework and collateral contacts and learned that on 11/26/24, the godmother was caring for the subject child at her residence. At approximately 6:30 PM, the subject child fell asleep, and the godmother placed her on her stomach on top of a blanket on the chaise of the couch. The godmother then fell asleep on the adjacent area of the couch. The godmother awoke due to smelling that the subject child had defecated. The godmother observed the subject child lying face down with her chin on the blanket, and her skin was blue and clammy. The godmother called 911 and called for her mother, who resided in the home. The godmother's mother performed cardiopulmonary resuscitation until emergency medical services arrived and took over life-saving measures. The subject child was transported to the hospital and pronounced deceased at 9:03 PM.

An autopsy was completed, and the final cause and manner of death were pending at the time of this writing. Hospital staff stated there were no marks or bruises to the subject child's body and no signs of trauma. Law enforcement stated the subject child's death was the result of asphyxiation and found no criminality related to the death. No arrests were made, and the law enforcement investigation was closed.

The allegation of Inadequate Guardianship was not added and substantiated against the mother, despite that she was aware the godmother did not have appropriate sleep provisions for the subject child and did not provide such provisions. The mother, the 4-year-old sibling, and the godmother's child were not fully interviewed regarding safety and risk. The record provided conflicting information regarding whether the godmother's boyfriend and sister were present at the time of the subject child's death, and neither party was interviewed. ACS was made aware that the subject child's alleged father had another infant child. That child's safety was not assessed, and safe sleep guidelines were not reviewed with the father. The surviving siblings were not added to the CPS investigation, and the Risk Assessment Profile was completed inaccurately.

Bereavement services were offered on behalf of all parties. The godmother was engaged in individual therapy. The godmother and mother both continued to engage in their previously established preventive service cases to address the

ongoing needs of the surviving children. At the time of case closure, the surviving siblings were residing with a paternal aunt as part of a plan created by the mother, and the godmother's child remained at her father's residence. The surviving children were deemed safe with their respective caregivers.

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?** No

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 an appropriate determination of the allegations against the godmother (GM); however, the allegation of IG was not added or substantiated against the BM. The Safety Assessment identified the OC's medical needs as a safety factor; however, the record did not reflect concerns for the OC's medical care. Therefore, there were no safety factors, and the safety decision should have been #1.

Was the decision to close the case appropriate? Yes

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:

Casework was not commensurate with case circumstances. The allegations of IG was not added and substantiated against

the BM. The RAP was completed inaccurately. Full interviews were not conducted with all case members. Safe sleep guidelines were not reviewed with the SC's father, who had another infant child.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The allegation of IG was not added and substantiated against the BM. The evidence supported that the BM was aware the SC was sleeping in an unsafe sleep environment while in the GM's care and did not provide appropriate sleep provisions.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the New York City Regional Office if further guidance is needed.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The BM, GM's partner, 4yo SS, and 7yo OC were not fully interviewed regarding safety and risk. Alcohol/substance use was not discussed with the BM, despite an alcohol bottle and ashes being observed in her home. The BF's other child was not assessed.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP did not reflect an elevated risk rating; however, the allegations of IG and DOA/Fatality were substantiated against the GM.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.
Issue:	Failure to provide safe sleep education/information
Summary:	Safe sleep guidelines were not discussed with the BF of the SC, despite that ACS was made aware that the BF had another infant child.
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 and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.
Issue:	Case record contains information that is relevant, useful, factual and objective

Summary:	The SSs of the SC were not added to the fatality investigation, and therefore, their safety and future risk was not adequately documented in the case record.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/26/2024 **Time of Death:** 09:03 PM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 07:55 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

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	2 Month(s)
Deceased Child's Household	Mother	No Role	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role		4 Year(s)
Other Household 1	Other Adult - Godmother of SC	Alleged Perpetrator	Female	27 Year(s)
Other Household 2	Other Child - Godmother's Child	No Role	Female	7 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS coordinated their investigation with LE, assessed the safety of the surviving children, conducted a CPS history review, and completed casework and collateral contacts.

ACS interviewed the godmother (GM) and learned that on 11/26/24, before 2:00 PM, the BM contacted the GM stating she was overwhelmed. The GM offered to care for the SC and picked the SC up from the BM's residence shortly after 2:30 PM. The GM stated the SC was in her bassinet with a bottle propped when she arrived. The GM got the SC dressed and left the BM's residence. The GM took the SC to visit her child (OC) at the OC's father's residence. The GM returned to her residence and received a video call from the BM's case planner, who wanted to assess the SC. The case planner's assessment of the SC was not reflected in the case record. The GM gave the SC to her mother and took a shower. The GM's mother told her to come get the SC, as the SC had fallen asleep. The GM placed the SC on the "L" chaise portion of the couch, on top of a fuzzy blanket. The GM stated the SC was on her stomach, and her head was facing the side. The GM laid on the long end of the couch and fell asleep. The GM awoke around 7:50 PM, as she could smell that the SC had defecated. The GM tickled the SC's foot, but she did not respond. The GM picked the SC up and noticed the SC was limp and clammy, had bluish-colored skin, and was not breathing. The GM called 911 while the GM's mother performed CPR. EMS arrived and transported the SC to the hospital, where she was pronounced deceased. The GM's mother was interviewed and corroborated the GM's version of events. The BM stated she was made aware of the fatal incident after receiving a phone call from the GM.

The GM stated she did not have safe sleep provisions for the SC and that the SC slept on the couch while at the GM's residence. The GM stated the BM was aware the SC did not have a bassinet or crib for the SC. When interviewed, the BM stated she was unsure if the SC had safe sleep provisions and that the GM's mother ordered a portable crib, but it had not arrived yet. The GM reported that she had watched the SC three times since her birth, and the BM reported that the GM had cared for the SSs in the past.

The GM stated the BM brought the SC to the doctor on the morning of the fatal incident, and the SC received a vaccination; however, this was not confirmed with the pediatrician, and it was unknown what vaccination the SC received. The GM stated that the BM was told to provide the SC with a fever reducer, but neither the GM nor the BM provided any medication. The record did not reflect contact with the SC's pediatrician.

The surviving children were deemed safe in the care of their respective caregivers.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Pending

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

Comments: There is no OCFS-approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070858 - Deceased Child, Female, 2 Month(s)	070862 - Other Adult - Godmother of SC, Female, 27 Year(s)	DOA / Fatality	Substantiated
070858 - Deceased Child, Female, 2 Month(s)	070862 - Other Adult - Godmother of SC, Female, 27 Year(s)	Inadequate Guardianship	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:

The 4yo SS and 7yo OC were not fully interviewed. The SC's pediatrician was not contacted. It was unclear from the record if the BM's case planner, who conducted a video call with GM shortly before the fatal incident, was contacted.

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 RAP did not reflect an elevated risk rating, despite that the SC's death was determined to be the result of maltreatment by the GM.

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?	☐	☒	☐	☐

Explain as necessary:
No children needed to be removed.

Legal Activity Related to the Fatality

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

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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The record did not reflect that burial assistance was offered. DV services were offered to the BF of the OC due to DV history; however, they were refused. The BM and GM continued to engage in preventive services following the SC's death.

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:
Services were offered on behalf of the surviving children.

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:
Bereavement services were offered to all parties. The GM was engaged in individual therapy following the SC's death. Referrals were made on behalf of the BM. The BM and GM continued to engage in preventive services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/08/2024	Other Child - GM's Child, Female, 6 Years	Other Adult - Father of OC, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes

Other Child - GM's Child, Female, 6 Years	Other Adult - Father of OC, Male, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
The SCR report alleged that on 1/8/24, while intoxicated, the BF of the OC physically assaulted the GM in the presence of the OC. The BF hit the GM with a mason jar, and she sustained a knot on her forehead and a laceration on her lip and left leg. There was a history of the BF being physically aggressive toward the GM in the presence of the OC. The OC did not sustain any injuries, and the GM had an unknown role.

Report Determination: Unfounded | **Date of Determination:** 03/25/2025

Basis for Determination:
ACS found there was not a fair preponderance of evidence to substantiate the allegations. ACS reported that the OC did not observe the incident between her BF and the GM. The basic needs of the OC's were met. ACS was unable to communicate with the BF of the OC throughout the investigation.

OCFS Review Results:
ACS initiated their investigation within 24 hours, assessed the safety of the OC, and referred the GM to appropriate services. ACS did not conduct full interviews with the GM and OC. There were missed opportunities to contact collateral sources, including the OC's pediatrician and out-of-state child protective agencies.

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:
The GM and OC were not fully interviewed regarding safety and risk. The GM was only interviewed regarding the allegations of the report. The OC was not interviewed specifically about the allegations of the report or concerns related to domestic violence.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
ACS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The record did not reflect that ACS contacted that out-of-state child protective agency in which the GM and OC previously resided, despite supervisory directive to do so. The CPS investigation was closed prior to speaking with the OC's pediatrician regarding her chronic medical needs, and the case record reflecting the OC was not up to date medically.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/14/2023	Sibling, Female, 4 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Female, 4 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 23 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 23 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 23 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 23 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Report Summary:
The SCR report alleged that the BM used marijuana and alcohol daily. The SSs suffered from asthma and, as a result, would cough, choke, and need an inhaler. The BM acted erratically and hit the 4yo SS with a closed fist, and she sustained bleeding and swelling to her lip. The BM struck the then 1yo SS with her fist in the chest and hit him with a slipper. The BM left the SSs with unknown individuals and did not make a plan for them. The BM left the then 1yo SS home alone. The home was infested with bedbugs, and the 4yo SS had bug bites. The SSs did not have beds. The SSs were hungry and not fed. The SS's clothing was dirty and not appropriate for the weather.

Report Determination: Unfounded | **Date of Determination:** 02/12/2024

Basis for Determination:
ACS unsubstantiated the allegations against the BM. ACS found the children's basic needs were being met, and there was adequate food, clothing, and shelter for the children. ACS determined the BM provided appropriate supervision and had familial support. There was no evidence of substance or alcohol use in the home. No marks or bruises were observed on the children, who were brought to the CAC for medical clearance and appeared well.

OCFS Review Results:
ACS appropriately reassigned this case from FAR to an investigation due to the allegations being ineligible for FAR. ACS initiated their investigation within 24 hours and assessed the safety of the children. Concerns regarding the BM's substance and alcohol misuse were not explored, and it was not confirmed if the children suffered from asthma. Safe sleep information was not provided to the BM, despite that she was pregnant. The SS's biological fathers were not located, notified, or interviewed. The RAP was completed inaccurately.

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

Issue:

Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:

The record did not reflect that substance and alcohol use was discussed with the BM, despite allegations of misuse in the SCR report. Conversations regarding the children needing a sober caretaker were not documented in the record. It was not explored if the children were diagnosed with asthma.

Legal Reference:

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

Action:

ACS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.

Issue:

Failure to provide safe sleep education/information

Summary:

ACS did not provide safe sleep guidelines to the BM, who was determined to be two months pregnant at the time of case closure. The record did not reflect that the BM had safe sleep provisions for the child.

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 and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

The record did not reflect attempts to locate, notify, or interview the BF's of the two SSs.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The BM's mental health diagnoses were not reflected in the Risk Assessment Profile, and therefore, the overall risk rating was inaccurate.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/10/2023	Sibling, Female, 4 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Far-Closed	No
	Sibling, Female, 4 Years	Mother, Female, 23 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 4 Years	Mother, Female, 23 Years	Internal Injuries	Far-Closed	

Sibling, Female, 4 Years	Mother, Female, 23 Years	Lacerations / Bruises / Welts	Far-Closed
Sibling, Female, 4 Years	Mother, Female, 23 Years	Lack of Supervision	Far-Closed
Sibling, Female, 4 Years	Mother, Female, 23 Years	Swelling / Dislocations / Sprains	Far-Closed
Sibling, Male, 1 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Male, 1 Years	Mother, Female, 23 Years	Inadequate Guardianship	Far-Closed
Sibling, Male, 1 Years	Mother, Female, 23 Years	Internal Injuries	Far-Closed
Sibling, Male, 1 Years	Mother, Female, 23 Years	Lacerations / Bruises / Welts	Far-Closed
Sibling, Male, 1 Years	Mother, Female, 23 Years	Lack of Supervision	Far-Closed
Sibling, Male, 1 Years	Mother, Female, 23 Years	Swelling / Dislocations / Sprains	Far-Closed

Report Summary:
The SCR report alleged that on multiple occasions, the BM was verbally and physically aggressive toward the SSs and yelled and screamed at them. The BM struck the SSs in the mouth with a closed fist and hit the then 1yo SS in the chest with a closed fist or slipper. Once, the 4yo SS sustained a bloody and swollen lip. It was unknown if the then 1yo SS was injured. The SSs had asthma, and the BM smoked cigarettes and marijuana around the SSs. As a result, the SSs choked, coughed, and required an inhaler. The home was infested with bedbugs, which the BM failed to address. The 4yo had bedbug bites. The BM had several individuals in and out of the residence. Once there was a gun in the home.

OCFS Review Results:
This FAR case was appropriately re-tracked as an investigation and closed on 12/14/23. Therefore, minimal casework was completed. All casework between 12/10/23 and 12/14/23 was adequate and timely.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/12/2023	Sibling, Female, 3 Years	Mother, Female, 23 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Female, 3 Years	Mother, Female, 23 Years	Lack of Supervision	Far-Closed	

Report Summary:
The SCR report alleged that on multiple occasions, the BM left the then 3yo SS alone outside of school and failed to walk the SS into the building to ensure the SS got where she needed to be. On multiple occasions, the BM dropped the SS off forty-five minutes early. The BM was also over an hour delayed picking up the SS on multiple occasions and failed to make adequate arrangements for a timely pickup.

OCFS Review Results:
ACS initiated their investigation, interviewed household members, and completed casework contacts. The BFs of the SSs were not engaged, despite being identified by the BM.

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

Issue:

FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible

Summary:

The BFs of the SSs were not notified, contacted, or engaged during the FAR case.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)

Action:

ACS must verbally inform the parent, guardian, or other person legally responsible about the areas of concern that triggered the report and explain that they must explore those concerns and assess the safety of any child named in the report or living in the household.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/26/2022	Sibling, Female, 2 Years	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 2 Months	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	
	Other Child - Minor Maternal Aunt, Female, 15 Years	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	
	Other Child - MA's Child, Female, 6 Months	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	

Report Summary:

The SCR report alleged that on 5/25/22, the BM was angry and became physically aggressive with the minor MA. The BM was erratic, screaming, and slamming car doors. The BM punched the MA in the head and pushed her to the ground. The MA did not sustain any visible injuries or marks. During the incident, the then 2yo SS, the then 2-month-old SS, and the MA's 6-month-old child (OC2) were present but not physically harmed.

Report Determination: Indicated | **Date of Determination:** 07/25/2022

Basis for Determination:

ACS found there was a fair preponderance of evidence to substantiate the allegation of IG against the BM. The BM was arrested for assaulting the 15yo MA while in the MGM's car with the children. The BM and MA got out of the car, and none of the children were injured during the altercation. The BM was issued an OP as a result.

OCFS Review Results:

ACS initiated their investigation within 24 hours, completed a CPS history check, conducted home visits, and assessed the children named in the report. The RAP did not identify a secondary caretaker, and the BM's history of domestic violence was not reflected. Safe sleep information was not discussed with the MA, who was the mother of the 6-month-old child. The record contained progress notes that detailed injuries to a child not named in this report.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP did not reflect the BM's history as a victim of domestic violence by the father of the then 2yo SS, which would have affected the overall risk rating. No secondary caretaker was identified, and therefore, the future risk of the 6-month-old other child was not reflected.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Issue:

Failure to provide safe sleep education/information

Summary:

The record did not reflect that safe sleep guidelines were discussed with the MA, who was the mother of the 6-month-old other child.

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 and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Issue:

Case record contains information that is relevant, useful, factual and objective

Summary:

Multiple progress notes appear to be copied from an unrelated case record, as the notes reference a child not named in this report and detail injuries and descriptions related to that child.

Legal Reference:

18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:

ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

The record did not reflect attempts to locate, notify, or interview the BF's of the children named in the report.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

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

[redacted]

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

The BM had one unfounded CPS investigation from 3/2020 with allegations of IG regarding the 4yo SS.

Known CPS History Outside of NYS

The BM had no known CPS history outside of New York State. The GM resided out-of-state prior to the SC's death, and the record did not reflect that inquiries were made to the out-of-state agency regarding any CPS history for the GM.

Preventive Services History

The BM had an open services case that began on 8/14/23 to assist the BM with services due to her MH history. The SC was not added to the FSS until after her death and was subsequently removed. The case remains open at the time of this writing to assist the BM with services following the death of the SC.

The GM had an open services case that began on 2/8/24 after the GM was a victim of DV perpetrated by the BF of the OC, and to assist the GM with educational and medical services for the OC. The case remains open at the time of this writing to continue to assist the GM in addressing the OC's needs.

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

Criminal Charge: Endangering the welfare of a child	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
05/25/2022	The BM	Unknown	Unknown
Comments:	The BM was charged with Endangering the Welfare of a Child following an incident where the BM assaulted the MA in the presence of the children.		

Criminal Charge: Assault	**Degree:** 3		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
05/25/2022	The BM	Unknown	Unknown
Comments:	The BM was charged with Assault 3rd following an incident where the BM assaulted the MA in the presence of the children.		

Criminal Charge: Other - Resisting Arrest and Disorderly Conduct	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**

05/25/2022	The BM	Unknown	Unknown
Comments:	The BM was charged with resisting arrest and disorderly conduct following an incident where the BM assaulted the MA in the presence of the children.		

Have any Orders of Protection been issued? Yes	
From: 05/25/2022	**To:** Unknown
Explain: An OP was issued against the BM protecting the SSs, the MGM, MA, and MA's child due to an incident in which the BM assaulted the MA in the presence of the children and was subsequently arrested.	

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