Child Fatality Report

Report Identification Number: NY-24-120

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

Issue Date: Apr 08, 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: 1 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 05/21/2023
Initial Date OCFS Notified: 12/20/2024

Presenting Information

An SCR report was received on 12/20/24 alleging that on 5/21/23, the subject child passed away while in the care of the mother, father, and aunt. On 12/7/23, toxicology results for the child came back positive for fentanyl, fluorophen fentanyl, xylazine, morphine, codeine, and tramadol. The multiple drugs found in the child's system contributed to his death. On 11/28/24, the mother gave birth to another child (the afterborn sibling). Due to the circumstances surrounding the subject child's death, there was concern for the wellbeing of the sibling while in the care of the mother, father, and aunt.

Executive Summary

This report concerns the death of the 1-year-old subject child that occurred over one year ago, on 5/21/23. The death was originally reported on 5/21/23 and investigated by the Administration for Children's Services (ACS), and the Office of Children and Family Services (OCFS) issued a fatality report (NY-23-048) at that time. On 12/20/24, new information regarding the child's cause of death generated a new SCR report. At the time of the child's death in 2023, he resided with his mother, father, and an aunt. There were no surviving children at that time; however, the mother gave birth to another child on 11/28/24, hereinto referred to as the sibling.

ACS did not interview the mother or aunt regarding the newly identified concerns surrounding the subject child's death. ACS documented no attempts to locate the child's father, despite also being a subject of the report. As there was no new information gathered surrounding the death, the account of events leading up to the child's death is as reported originally in the historical investigation. On 5/20/23, the mother was home with the child. The child took an unusually long nap (4:00-7:30PM) and the mother had to wake him up. When she did so, the child had wet the bed, and his eyes were swollen. The mother cleaned his eyes with warm water, changed him, and fed him. The mother left for work that evening and the child stayed home with the aunt. Around 8:00AM the next morning (5/21/23), as the mother was arriving home, the aunt called the mother because the child was snoring. It was noted, in February 2023, the child had his adenoids removed due to snoring. The mother administered a saline nebulizer treatment and the child's breathing improved. The mother then went to her room and the child was left to sleep longer. At about 9:00AM, the aunt alerted the mother that the child was still asleep, which she felt was odd. The mother tried to wake the child and tried to open his eyes. The mother yelled, waking the father who had been asleep in his room (while they lived together, the parents maintained separate bedrooms). The family did not think to call 911, and the father drove them to the hospital. The mother held the child in the car and handed him over to medical staff upon arrival at the hospital; 9:46AM. On arrival, the child was non-responsive, not breathing, and had no pulse or heartbeat. The child was pronounced deceased approximately half-an-hour later, at 10:19AM.

The medical examiner was notified and performed an autopsy on the child. In December 2023, previously outstanding toxicology results were received, and the cause of death was ruled homicide. Despite numerous attempts, the ME's office would not release the autopsy report to ACS, pending DA approval, therefore the manner of death remained unknown. Toxicology results confirmed the child was positive for fentanyl, fluorophen fentanyl, xylazine, morphine, codeine, and tramadol. ACS learned on 12/20/24 of an impending arrest regarding the fatality, though no further information was obtained. At the close of the investigation, the mother had not been arrested. The status of the father was unknown.

The afterborn sibling was removed from the mother's care on 12/20/24 on an emergency basis. Article 10 petitions were filed against the mother and aunt on behalf of the subject child and sibling on 12/23/24 and the sibling's removal was upheld. It was unknown why ACS did not file against the subject child's father, who was present at the time of the fatality. The subject child and sibling did not share the same father, and the sibling was released to his father on 1/14/25.

Allegations regarding the subject child against the mother, father, and aunt (the child's caretakers at the time of death) were substantiated. Additionally, as the mother and aunt were the sibling's current caretakers, they were substantiated for allegations regarding the sibling as well.

Services related to the fatality were offered in 2023.

PIP Requirement

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:

The investigation into the new allegations surrounding the subject child's death was closed on 2/14/25. A family services

stage (FSS) was opened following the sibling's removal and remained open at the time this report was written due to ongoing service needs.

Required Actions Related to the Fatality

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 subject child's father, a subject of the report, was not interviewed regarding the new allegations surrounding the child's death. The mother and aunt were seen face-to-face but not interviewed regarding the allegations.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:	Mandated reporters did not report potential abuse or maltreatment of a child
Summary:	Progress notes reflected an ACS caseworker was notified of the toxicology at death by LE on an unknown date after the 2023 investigation. As this was new information, it should have been reported to the SCR. LE or the ME could have also reported it.
Legal Reference:	SSL 413 and 415
Action:	Mandated reporters are required to report or cause a report to be made when they have reasonable cause to suspect that a child is being abused or maltreated or is at risk of such abuse or maltreatment.

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	There was no 30-Day Safety Assessment documented. The failure to document the assessment did not impact the sibling's safety.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 30-Day Safety Assessment in Connections.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/21/2023 **Time of Death:** 10:19 AM

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

County where fatality incident occurred: Queens
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? Yes
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	Aunt/Uncle	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)

LDSS Response

On 12/20/24, ACS received a report containing new information regarding the death of the subject child. The child's death was originally reported on 5/21/23. Upon receipt of the new report, ACS initiated their investigation within 24 hours and coordinated with law enforcement. ACS contacted the source of the report, completed a CPS history check which revealed the previously investigated fatality, and informed the DA of the new information learned regarding the death. The safety of the sibling was assessed, and an emergency removal was conducted on 12/20/24 and upheld in court on 12/23/24.

No new interviews of the subjects (the mother, aunt, and father) were conducted.

ACS learned from law enforcement that their original investigation into the 5/21/23 death was re-opened on 12/7/23 when they had a conference with the ME's office regarding the positive toxicology report. Additionally, the child was positive for pneumonia, three other viruses, and a bacterial infection. It was further learned that the child's father was the subject of a Drug Enforcement Task Force investigation where large quantities of fentanyl had been recovered and federally indicted. It was unknown where the fentanyl was recovered from, but the case address was not subject to the investigation. The mother refused to participate in the law enforcement investigation without an attorney. Progress notes reflected the father was arrested and detained, though no further information was documented of his charges or whereabouts.

ACS made multiple attempts to obtain the final autopsy report, but release of the report was continually denied by the ME's office due to the DA's involvement as the cause of death was homicide.

Family court proceedings remained ongoing. At the close of the investigation, the sibling had been released to his father with an Order of Supervision and Order of Protection against the mother. At the time this fatality report was written, the family remained under ACS supervision. Services were offered to the mother in connection with the FSS case. Fatality-related services had previously been offered in the initial fatality investigation.

ACS substantiated the allegations of DOA/Fatality, Poisoning/Noxious Substance, and Inadequate Guardianship against the mother, father, and aunt regarding the subject child as they were his caretakers at the time of death and failed to provide proper care, resulting in his death. Inadequate Guardianship was also substantiated against the mother and aunt regarding the afterborn sibling based on the seriousness of their failure to provide proper care to the subject child. The same allegation was unsubstantiated against the subject child's father regarding the sibling as he had no role in the sibling's care. The sibling remained in the care of his father at the close of the investigation.

Official Manner and Cause of Death

Official Manner: Homicide

Primary Cause of Death: Unknown

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
070478 - Deceased Child, Male, 1 Year(s)	070480 - Father, Male, 38 Year(s)	DOA / Fatality	Substantiated
070478 - Deceased Child, Male, 1 Year(s)	070480 - Father, Male, 38 Year(s)	Inadequate Guardianship	Substantiated
070478 - Deceased Child, Male, 1 Year(s)	070480 - Father, Male, 38 Year(s)	Poisoning / Noxious Substances	Substantiated
070478 - Deceased Child, Male, 1 Year(s)	070479 - Mother, Female, 36 Year(s)	DOA / Fatality	Substantiated
070478 - Deceased Child, Male, 1 Year(s)	070479 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
070478 - Deceased Child, Male, 1 Year(s)	070479 - Mother, Female, 36 Year(s)	Poisoning / Noxious Substances	Substantiated
070478 - Deceased Child, Male, 1 Year(s)	070481 - Aunt/Uncle, Female, 27 Year(s)	DOA / Fatality	Substantiated
070478 - Deceased Child, Male, 1 Year(s)	070481 - Aunt/Uncle, Female, 27 Year(s)	Inadequate Guardianship	Substantiated

070478 - Deceased Child, Male, 1 Year(s)	070481 - Aunt/Uncle, Female, 27 Year(s)	Poisoning / Noxious Substances	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?	☒	☐	☐	☐
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 30-Day Safety Assessment was not entered into Connections; however, the sibling's safety was adequately assessed and documented in notes.
While LE was contacted, diligent efforts to obtain the father’s current legal status were not documented.

Fatality Safety Assessment Activities

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

Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☒	☐	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
ACS conducted an emergency removal of the sibling on 12/20/24. ACS then filed in family court on 12/23/24 and the removal was upheld at that time.

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:
12/23/2024	There was not a fact finding	There was not a disposition
Respondent:	070479 Mother Female 36 Year(s)	
Comments:	ACS filed Article 10 petitions in family court against the mother on behalf of the subject child and sibling. A stay-away Order of Protection was issued against the mother on behalf of the sibling, with a carve out for ACS approved supervised visits. The record was not clear as to why the subject child's father was not filed against. The sibling's removal was upheld and the sibling was subsequently released to his father on 1/14/25. Further orders were made that the sibling's parents could not obtain a passport for the sibling without court permission, the sibling's father could only use ACS approved babysitters/daycares, and the Order of Protection against the mother remained in place. Fact finding was scheduled for June 2025.	

Have any Orders of Protection been issued? Yes	
From: 12/23/2024	**To:** Unknown
Explain: Upon the filing of Article 10 petitions against the mother, an Order of Protection was issued against the mother regarding the sibling. The mother was to have ACS approved supervised contact only.	

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 sibling was briefly placed into foster care then released to the care of his father. An FSS was opened to provide monitoring and oversight and ensure compliance with orders. The mother was to engage in mental health and parenting skills services. The subject child's father was not re-engaged as part of this fatality investigation.

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:
In response to the new information learned regarding the subject child's cause of death, the sibling was briefly provided foster care services until his release to his father's care. The sibling was not alive at the time of the subject child's death, therefore, there were no bereavement service needs.

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:
The family was originally referred to bereavement services in 2023. It was unknown if they ever engaged.

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)
05/21/2023	Deceased Child, Male, 1 Years	Mother, Female, 36 Years	DOA / Fatality	Unsubstantiated	No
	Deceased Child, Male, 1 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	

Deceased Child, Male, 1 Years	Father, Male, 38 Years	DOA / Fatality	Unsubstantiated
Deceased Child, Male, 1 Years	Father, Male, 38 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 1 Years	Aunt/Uncle, Female, 27 Years	DOA / Fatality	Unsubstantiated
Deceased Child, Male, 1 Years	Aunt/Uncle, Female, 27 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report alleged that on 5/21/23, at an unknown time, the mother and father observed the subject child asleep and snoring. Later, the parents realized the child was unresponsive. The father notified emergency medical services (EMS) that the child was unresponsive. Approximately 30-40 minutes passed, and EMS did not arrive. The mother, father, and maternal aunt then brought the child to the hospital at approximately 9:30AM. Upon arrival, the child had no pulse. Resuscitative measures were attempted for approximately 30-45 minutes; however, the child was pronounced deceased at 10:19AM. The child was an otherwise healthy child, and the parents did not have an explanation for his death.

Report Determination: Unfounded | **Date of Determination:** 06/29/2023

Basis for Determination:
ACS unfounded the report. The autopsy report was pending, but preliminarily there were no signs of abuse, and no internal or external injuries found. Multiple tests were outstanding. The child was up to date medically according to the pediatrician. Law enforcement closed their case with no arrests and collateral sources reported no concerns for the mother or father. Bereavement counseling was offered, and the case was closed.

OCFS Review Results:
This fatality was previously reviewed as NY-23-048 and that review resulted in no citations.

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

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

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

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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: Other - Drug Trafficking **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Unknown	Father	Unknown	Unknown
Comments:	In the 5/21/23 historical investigation it was noted the father had a criminal history pertaining to drug distribution and was on bail supervision release until 2028. No attempts to gather additional information were documented in that investigation. Warrants were executed on 3/21/23 by the Drug Enforcement Task Force as a result of a long-term investigation naming the father (and others), where large quantities of fentanyl were recovered. The father's current legal circumstances were unknown.		

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