Child Fatality Report

Report Identification Number: NY-25-014

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

Issue Date: Jun 16, 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: Queens
Gender: Male
Date of Death: 08/05/2023
Initial Date OCFS Notified: 02/14/2025

Presenting Information

While in the care of the subject mother (SM) and the subject father (SF), the 2-month-old subject child (SC) had an unknown amount of ketamine in his system. As a result, on August 5, 2023, the SC was found unresponsive by both subject parents and was pronounced deceased at an unknown time. The initial fatality investigation was closed on October 3, 2023 as the final autopsy report was pending. Law enforcement closed their case as well. On January 10, 2025, the medical examiner reported that ketamine was found in the SC's toxicology. As a result, law enforcement and ACS re-opened the case and initiated a homicide investigation. At the time of SC's death, the subject parents were residing together; however, the SM has since moved to an unknown location in another state. The SC slept in a crib; however, the details surrounding the crib were unknown.

Executive Summary

This report concerns the death of a 2-month-old male child which occurred while in the care of the subject mother and subject father. The New York City Administration for Children's Services (ACS) received an SCR report regarding the subject child's death on February 14, 2025, which was a subsequent report to a January 1, 2025, additional information DOA/Fatality report. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, and Poisoning/Noxious Substances against the subject father and subject mother regarding the subject child. At the time of his death, the subject child was residing with the subject parents. There was one surviving sibling born to a different mother (OA) and the subject father.

On the morning of August 5, 2023, the subject mother found the subject child unresponsive in his bassinet at 11:20AM. The subject father and subject mother transported the subject child via car to the hospital. When they arrived, the subject mother ran into the hospital carrying the subject child. Life-saving measures were taken for 40 minutes to no avail before the subject child was pronounced deceased. The allegations of Inadequate guardianship and DOA/fatality against the subject parents were unfounded and the case was closed on October 3, 2023. The final autopsy results were pending at case closing.

The medical examiner reported that the subject child's toxicology, from the autopsy conducted in 2023, came back revealing that the subject child's death was an overdose of ketamine, and the manner of death was a homicide. Law enforcement and ACS re-opened the case and investigated the fatality as a homicide.

ACS made several home visits to observe the surviving sibling. The surviving sibling did not have any additional information to add regarding the incident due to her developmental age at the time of incident. The surviving sibling's daycare provider reported no concerns. The surviving sibling was assessed to be safe during and at the close of the case.

ACS met with the subject father who denied drug use or a history of drug use. However, on March 23, 2025, the subject father was arrested and charged with Criminal Possession of a Controlled Substance.

ACS requested a courtesy visit from CPS in the state with which the subject mother moved to ascertain if any children were currently residing in her home. No children were found to be residing in her home and the subject mother denied having any children in her care. The subject mother denied ketamine use.

ACS made the appropriate determination to substantiate the allegations against the subject parents regarding the death of the subject child as the child died of ketamine intoxication while being in the sole care of both subject parents. ACS had a legal consult regarding the case. They were advised that there was no basis to file an Article X neglect petition at the time of case closing.

The family declined bereavement and counseling services offered by ACS. The case remains open with law enforcement pending additional toxicology results from the medical examiner's office.

PIP Requirement

For citations identified in historical cases, Westchester County Department of Social Services (WCDSS) will submit a PIP to the Westchester Regional Office within 45 days of receipt of this report. The PIP will identify action(s) WCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, WCDSS will review the plan and revise as needed to address

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? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:

ACS substantiated the allegations of DOA/fatality, IG and P/Nx regarding the fatality. The SM had no other children in her care. The SF had a child with another woman. He still sees the SS but all his visitation with that child are supervised by the OA.

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: 08/05/2023 **Time of Death:** 12:07 PM

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	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Other Household 1	Sibling	No Role	Female	3 Year(s)

LDSS Response

On February 14, 2025, ACS received a report regarding the death of the SC. ACS initiated their investigation within 24 hours and coordinated their efforts with LE. ACS contacted the source of the report and completed a CPS history check regarding the family. ACS immediately made several attempts at locating the SS to assess safety. The SS was located on February 16, 2025, and was deemed safe.

This fatality was previously investigated and initially reported on August 5, 2023. The allegations of DOA/Fatality and Inadequate guardianship were unsubstantiated against the subject parent's and the case was closed on October 23, 2023. At the time of closing, autopsy results were still pending. On January 10, 2025, the medical examiner reported that ketamine was found in the SC's toxicology report resulting in ACS and law enforcement reopening the case and investigating it as a homicide. At the time of the SC's death, the subject parents resided together, they have since separated and the SM moved to a different state.

ACS interviewed the SM on February 19, 2025, via phone. The SM reported that the SF has not been her husband for over a year, and she had no contact with him. ACS interviewed the SM via phone again on March 18, 2025. When asked, she denied she ever used ketamine. The SM advised that she did not understand why everyone keeps asking her about ketamine and adamantly denied that she ever used the drug. She advised ACS that she would not be answering any additional questions, nor would she be answering anymore phone calls from them.

ACS interviewed the SF, SS and the OA on February 20, 2025, in the home of the OA. The OA informed ACS that the SS is doing well and does not have any medical conditions. The OA informed ACS that she co-parented with the SF. The SF explained that the SS resided with the OA and that he relocated to a new address. ACS did not observe any hazardous conditions in the OA's home. The SS was free of any visible marks or bruises. Both the OA and SF denied having any physical or mental health conditions. Both denied having any domestic violence issues. The OA stated that she and the SF had a respectful relationship. She reported that the SF was an active part of the SS's life. However, the OA reported that she supervises all contact between the SF and SS. Both parents denied the use of substances. They denied using physical discipline with the SS. The SF was asked to take a drug test, he declined. He reported he would not be taking any additional calls from ACS.

ACS contacted numerous collateral resources. Services were offered to the family and declined. The SS was deemed safe in the care of the OA. To date, no criminal charges were brought against either of the subject parents regarding the death of the SC.

Official Manner and Cause of Death

Official Manner: Homicide

Primary Cause of Death: From an injury - external cause

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070236 - Deceased Child, Male, 2 Month(s)	070237 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated

070236 - Deceased Child, Male, 2 Month(s)	070237 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
070236 - Deceased Child, Male, 2 Month(s)	070237 - Mother, Female, 27 Year(s)	Poisoning / Noxious Substances	Substantiated
070236 - Deceased Child, Male, 2 Month(s)	070238 - Father, Male, 26 Year(s)	DOA / Fatality	Substantiated
070236 - Deceased Child, Male, 2 Month(s)	070238 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
070236 - Deceased Child, Male, 2 Month(s)	070238 - Father, Male, 26 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 SM was residing in another state and was interviewed by phone. The SF was interviewed face-to-face.

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:
The initial fatality report was completed on August 8, 2023, regarding the deceased SC. The SS age 3, resided with the OA. The SF did not reside in the home but had regular visits with the SS. The SS was seen free of marks and bruises. The SM was no longer living with the SF, and she was residing in another state.

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 family was offered grief services, however declined.

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? There was no legal activity.

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

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
Bereavement counseling	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒
Funeral arrangements	☐	☐	☐	☐	☐	☒
Housing assistance	☐	☐	☐	☐	☐	☒
Mental health services	☐	☐	☐	☐	☐	☒
Foster care	☐	☐	☐	☐	☐	☒
Health care	☐	☐	☐	☐	☐	☒
Legal services	☐	☐	☐	☐	☐	☒
Family planning	☐	☐	☐	☐	☐	☒
Homemaking Services	☐	☐	☐	☐	☐	☒
Parenting Skills	☐	☐	☐	☐	☐	☒
Domestic Violence Services	☐	☐	☐	☐	☐	☒
Early Intervention	☐	☐	☐	☐	☐	☒
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒
Child Care	☐	☐	☐	☐	☐	☒
Intensive case management	☐	☐	☐	☐	☐	☒
Family or others as safety resources	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The family was offered grief services. The family declined services stating they were dealing with the SCs death on their own.

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 offered grief services. The family declined services stating they were dealing with the SCs death on their own.

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)
08/05/2023	Deceased Child, Male, 2 Months	Mother, Female, 25 Years	DOA / Fatality	Unsubstantiated	No
	Deceased Child, Male, 2 Months	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Months	Father, Male, 24 Years	DOA / Fatality	Unsubstantiated	
	Deceased Child, Male, 2 Months	Father, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged that on August 5, 2023, the SM and the SF were home with the SC. At 8:30am, the SC woke up and the SM tried to feed him. The SC had no appetite, so the SM put him back to sleep. The SM checked on the SC at approximately 11:30am. The SC was unresponsive and bluish in color around his mouth and had vomit coming out of his

mouth. The SM and SF drove the SC to the hospital which took approximately ten minutes. The SM ran into the emergency room carrying the SC. Upon arrival to the hospital, the SC had no pulse, was unresponsive and had a body temperature of 93.4. Emergency medical staff attempted life-saving measures to no avail and the SC was pronounced deceased

Report Determination: Unfounded | **Date of Determination:** 10/03/2023

Basis for Determination:
ACS unsubstantiated the allegations of DOA/Fatality and IG against the SM and SF regarding the 2-month-old male subject child. The ACS investigation did not have a fair preponderance of evidence to support the allegations regarding the fatality. The preliminary autopsy report found no evidence of child abuse or neglect. There were no findings of internal/external injuries that resulted in the SC's death. The SM and SF had no other children in common. The SF had another child with a different mother (OA). The SS was seen, and she was deemed to be safe in the care of the OA. At case closing, the SM and SF were no longer together, and the SM relocated to another state.

OCFS Review Results:
ACS immediately initiated their investigation. The risk assessment profile was consistent with case circumstances. Progress notes were entered contemporaneously. The case determination was appropriate and supported the findings of the case investigation.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/02/2022	Sibling, Female, 1 Years	Father, Male, 23 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 1 Years	Father, Male, 23 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
Westchester County Department of Social Services (WCDSS) received an SCR report alleged that on 11/2/22, the SF engaged in a verbal dispute that escalated into a physical altercation with the OA in the presence of the 1-year-old female SS. During the altercation, the SF pushed the SS on the ground. As a result, the SS sustained a bruise on the left temple and cheek. The OA sustained a laceration by her eyebrow. The OA and the SS both required medical attention.

Report Determination: Unfounded | **Date of Determination:** 12/27/2022

Basis for Determination:
Based on information gathered WCDSS found no preponderance of evidence to substantiate the allegations of Inadequate Guardianship and Lacerations, Bruises, Welts against the SF regarding the SS. The SS was observed several times during casework contact with the family. The SS was never observed to have any marks/bruises or a negative impact as a result from the physical altercation that took place between the parents on 11/02/2022. The report was unsubstantiated and closed. The OA and SS moved to another state with friends.

OCFS Review Results:
WCDSS immediately initiated their investigation and completed a timely CPS history review. The child was assessed for safety within 24-hours. Progress notes were entered contemporaneously and required notifications was provided. However, WCDSS did not appropriately determine the case.

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

Issue:

Appropriateness of allegation determination

Summary:

WCDSS justified unsubstantiating the allegation of IG by stating the SS was not injured because of the physical incident between the parents; however, the definition of IG includes imminent danger of harm. The SS was found to have been in imminent risk of harm, given that the physical altercation occurred in her presence. The SF was arrested and charged with endangering the welfare of a child.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

WCDSS will refer to the CPS Program Manuel when determining the appropriateness of allegations and will consult with the regional office if further guidance is needed.

PIP Requirement:

WCDSS 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.

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 is no known CPS history outside of NYS.

Preventive Services History

01/10/25-04/29/25: a preventive services case was opened regarding the death of the 2-month-old SC. The initial fatality report was received on 08/05/23, with allegations of DOA/Fatality and Inadequate Guardianship against the SM and SF regarding the death of the SC. The initial case was unsubstantiated and closed on 10/3/23. At the time of case closure, the final autopsy report was still pending. Law enforcement closed their case as well. On 01/10/25, the medical examiner reported that ketamine was found in the SC's toxicology. This resulted in ACS and law enforcement to re-open their investigations and deeming the death as a homicide. Although ACS was aware that a substance was found in the SC's system since January of 2025, it wasn't until 02/14/25 that the medical examiner's office confirmed the substance was ketamine. An SCR report was promptly received. The FSS was open on 1/10/25, due to the concern that the subject father was still having contact with the 4yo SS that he shared with a different woman (OA). The SS was deemed safe in the care of the OA. The OA reported that she allowed the SF to have contact with the SS but only under her direct supervision. The family was offered grief services several times; however, despite strong urging from ACS declined to participate with services. The case was closed on 04/29/25, as services were no longer needed.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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