Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-016

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

Issue Date: May 21, 2025

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

- ☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- ☒ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.
- ☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- ☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 9 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 02/17/2025
Initial Date OCFS Notified: 02/18/2025

Presenting Information

An SCR report received on 2/18/25 alleged that on 2/17/25, the mother woke up at 6:00AM and fed the subject child a bottle and went back to sleep. At approximately 7:50AM, the mother woke up and found the child to be face-up and unresponsive in his crib. The mother called 911, law enforcement responded followed by emergency medical services (EMS). The mother and EMS both attempted CPR on the child. The child was transported to the hospital where he was pronounced deceased at 8:25AM. The mother had a significant history of drug misuse, which the SCR report alleged contributed to the child being born prematurely and having to undergo four major surgeries, including brain and open-heart surgery. The SCR report alleged the mother's drug misuse contributed to the child's death.

Executive Summary

This report concerns the death of the 9-month-old male subject child. The Administration for Children's Services (ACS) received an SCR report regarding the child's death on 2/18/25. At the time of the child's death, he resided with his mother and 2-year-old sibling. There was an open family services stage (FSS) due to prior CPS concerns, which led to the sibling's removal in the past. The mother and sibling were under an Order of Supervision at the time of the subject child's death. Despite efforts, ACS was not granted an Order of Supervision over the subject child. There was an Order of Protection limiting the father's contact.

On advice from their respective legal counsel, the parents refused to provide information regarding the events leading up to the subject child's death. As such, there was limited information gleaned about the timeline of events prior to the child being found unresponsive. The mother's refusal to sign requested releases of information hindered information gathering. From prior history, it was known that the child was born prematurely at 30 weeks in May 2024, with multiple medical complications underwent heart surgery in September 2024. The child was hospitalized from birth until 1/31/25. Due to a lack of medical releases, it was unknown what medical care the child received, or if any was required, between his discharge home and his death. The morning of 2/17/25, the mother fed the child a bottle around 6:00AM, then went back to sleep. The mother woke again around 7:50AM, checked on the child, and found him unresponsive, face-up, in his crib. Though initially reported the mother called 911, it was later learned the father called 911 at 7:49AM, which implied a violation of the Order of Protection, as it was also learned the sibling was present. Law enforcement and EMS arrived at the home and the child was carried out of the building with CPR in progress and placed inside the ambulance with compressions being continued. Life-saving efforts continued in transport and at triage; however, the child remained asystole and was pronounced deceased.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation closed. The medical examiner stated the child's heart was indicative of his historical surgical procedures, and the heart may be the cause of death, but they had not obtained all test results yet. The sleeping environment was reviewed with the medical examiner (a plush blanket and changing pad found inside the crib), and the medical examiner stated the sleeping environment was not hazardous. The investigator from the medical examiner's office attempted to assess the home; however, was not permitted by the father, and was unable to interview the mother as the mother was under the influence and unable to stay alert or answer questions. The investigator described the home as filthy and "not the safest environment for children." Photos received from law enforcement corroborated that assessment.

ACS was unable to make home visits as part of this investigation; however, obtained photographs of the home. The safety of the sibling was immediately assessed, and the sibling was removed on 2/18/25 and the removal was upheld in family court on 2/19/25. The sibling was placed in kinship foster care with a maternal aunt and their safety in placement was routinely assessed.

ACS inaccurately substantiated all allegations against the mother regarding the subject child, including DOA/Fatality.

The parents were offered bereavement services and funeral costs were covered by a community resource.

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?** No, sufficient information was gathered to determine some allegations only.
- **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 determination to indicate the report was appropriate, as the record supported substantiating, at minimum, Inadequate Guardianship for the subject child, and could have been added for the sibling as well. Allegations of PD/AM and DOA/Fatality regarding the subject child were not supported by the record or with the information available at the time.

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 determinations lacked adequate descriptions of how the evidence gathered supported the findings, and the record did not support the allegation determinations for PD/AM regarding the SC, DOA/Fatality regarding the SC, nor was IG considered for the sibling.
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 NYC Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/17/2025 **Time of Death:** 08:25 AM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 07:49 AM
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	Male	9 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)

Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Other Household 1	Father	No Role	Male	42 Year(s)

LDSS Response

On 2/18/25, ACS received a report regarding the death of the subject child, which occurred the day prior, on 2/17/25. ACS initiated their investigation within 24 hours, contacted the source of the report, informed the DA of the fatality, reached out to law enforcement, and completed a CPS history check regarding the family, which revealed prior child welfare history with ACS, as well as an open FSS. ACS assessed the safety of the surviving sibling and as a result, the sibling was removed and placed in kinship foster care on 2/18/25.

ACS was unable to interview either parent regarding the events leading up to the child's death, as they both stated they were advised by their respective attorneys to not discuss the matter.

ACS learned from law enforcement that the mother reported last feeding the child around 6:00AM on the morning of 2/17/25. The mother then went back to sleep and woke again just before 7:50AM, checked on the child, and found him unresponsive in his crib. Law enforcement responded to the 911 call and described the mother's behavior as "off" during their interactions. It was reported neither the father nor sibling were present; however, upon receipt of the 911 call, it was learned both were present, which violated an Order of Protection. When law enforcement returned to the home to conduct a re-enactment with the mother later that morning, the mother was highly intoxicated, and unable to speak or stay upright. Despite an Order of Protection, the father was in the home at that time and refused further entry. ACS was provided pictures taken by law enforcement, which depicted excess clutter, posing a safety hazard to both children, as there were items piled high, cluttered beds rendering them unusable, and what appeared to be a broken bottle of liquid medication left uncleaned on the floor.

ACS learned from agency staff supervising the FSS that the parents had not been compliant with services, specifically the mother had only completed one requested drug screen, despite being sent weekly. There had been conversations with legal about filing a violation against the mother due to noncompliance; however, the FSS team had been advised to give the mother additional time.

ACS spoke with the ME's office throughout the investigation; however, the final autopsy report was not available. The DA's office was awaiting the final autopsy report as well.

ACS was unable to gather medical information from the treating hospital, or the child's medical providers due to the mother refusing releases of information. The failure of the mother to sign necessary releases was not sufficient to substantiate DOA/Fatality, nor was the lack of an Order of Supervision. The mother's intoxication hours after the child was pronounced deceased was not sufficient to support substantiating PD/AM. Furthermore, as the condition of the home affected both the subject child and sibling, IG could have been considered for the sibling as well. Regardless of the stated concerns, the overall report was accurately indicated. The FSS remained open due to the sibling's foster care placement and services were being implemented.

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 NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070794 - Deceased Child, Male, 9 Month(s)	070795 - Mother, Female, 38 Year(s)	DOA / Fatality	Substantiated
070794 - Deceased Child, Male, 9 Month(s)	070795 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
070794 - Deceased Child, Male, 9 Month(s)	070795 - Mother, Female, 38 Year(s)	Parents Drug / Alcohol Misuse	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
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?	☒	☐	☐	☐

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:
An emergency removal was conducted on 2/18/25 and upheld in court on 2/19/25. The sibling's prior 1017 placement was not considered due to their violating the terms of court orders previously; however, the family provided another resource for the sibling and the sibling was placed with a maternal aunt.

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:
02/19/2025	There was not a fact finding	Article 10 Remand
Respondent:	070795 Mother Female 38 Year(s)	
Comments:	Based on information learned regarding the death of the subject child, ACS filed a violation petition in family court. A violation petition would restore the mother's previously resolved neglect petition (which had been resolved as an Adjournment in Contemplation of Dismissal). ACS requested and was granted the removal of the sibling. Family court proceedings regarding the violation petition were ongoing at the time this fatality report was written.	

Have any Orders of Protection been issued? Yes

From: 02/19/2025	To: Unknown

Explain:
Following the death, the sibling was removed from the parents care and the parents were permitted supervised contact.

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

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
Bereavement counseling	☐	☐	☒	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒
Funeral arrangements	☒	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☒	☐	☐	☐
Mental health services	☐	☐	☐	☐	☐	☒
Foster care	☒	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☒

Legal services	☐	☐	☐	☐	☐	☒
Family planning	☐	☐	☐	☐	☐	☒
Homemaking Services	☐	☐	☐	☐	☐	☒
Parenting Skills	☐	☐	☒	☐	☐	☐
Domestic Violence Services	☐	☐	☒	☐	☐	☐
Early Intervention	☐	☐	☐	☐	☐	☒
Alcohol/Substance abuse	☐	☐	☒	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒
Intensive case management	☒	☐	☐	☐	☐	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐
Preventive Services	☒	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
An FSS was open at the time of death. Following the death, the sibling was placed in kinship foster care. The service plan remained similar to prior plans; the parents were to engage in substance use evaluations, parenting skills, submit to drug screens, and engage in domestic violence counseling. The parents were re-referred to all services as they had not historically complied.

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 fatality, the sibling was removed and placed in kinship foster care. While a service need in direct response to the death was not identified, the sibling was receiving foster care services to address identified safety concerns.

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 service information was offered to the parents. The mother's attorney indicated the mother had started bereavement counseling. It was unknown if the father had engaged. Services related to the ongoing FSS service plan related to substance misuse, domestic violence, and parenting skills were offered as well.

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

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)
05/15/2024	Deceased Child, Male, 7 Days	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 7 Days	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report received on 5/15/24 alleged that the mother lost custody of the sibling due to drug misuse, including the use of Percocet. On 5/8/24, the mother gave birth to the subject child. Due to the mother's history, the subject child needed protection while in the mother's care.

Report Determination: Indicated

Date of Determination: 07/12/2024

Basis for Determination:
The allegation of Inadequate Guardianship was substantiated against the mother and added and substantiated against the father regarding the subject child. The Investigation Conclusion Narrative cited historical concerns regarding the mother's substance use while pregnant with the subject child, and the sibling's subsequent removal. Regarding both parents, there was an active family court case (neglect) regarding the sibling, in which neither parent had made progress with their service plan. The sibling remained in 1017 placement with a relative. There were derivative neglect concerns regarding the subject child based on the unresolved concerns that originally led to the sibling's placement.

OCFS Review Results:
The subject child was hospitalized for the duration of the investigation due to medical concerns at birth. ACS assessed the child would be in immediate/impending danger based off the parents' lack of progress regarding the sibling's original need for placement. ACS planned to file in family court and request the removal of the subject child as hospital discharge approached. ACS maintained contact with the hospital and at the time of case closing, the child was not ready for surgery or discharge. The FSS previously opened on 5/18/23 due to historical concerns and the sibling's removal remained open for monitoring.

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

Issue:
Adequacy of Progress Notes

Summary:

There was one instance of a progress note entered into the case record regarding another family, despite the subject family members being selected as the "focus" of the casework contact.

Legal Reference:

18 NYCRR 428.5

Action:

ACS will accurately document all casework activity into progress notes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/28/2024	Sibling, Male, 1 Years	Mother, Female, 37 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes
	Sibling, Male, 1 Years	Father, Male, 41 Years	Inadequate Guardianship	Substantiated	

Report Summary:

An SCR report received on 2/28/24 alleged that on an on-going basis, the father was physically aggressive toward the mother and engaged in self-injurious behaviors while in the presence of the sibling. On one occasion, the father gave himself a black eye and attempted to blame the mother for the self-inflicted injury. About 3 weeks prior, the father was irate, screaming, and attempted to get into the mother's home, while the sibling was inside the home.

Report Determination: Indicated | **Date of Determination:** 03/19/2024

Basis for Determination:

The Investigation Conclusion Narrative reflected the allegation of Parent's Drug Alcohol Misuse was substantiated against the mother as NARCAN was administered to the mother, and one of the mother's drug screens was positive for fentanyl. The allegation of Inadequate Guardianship against the father was substantiated because the mother was a victim of domestic violence (not specified) perpetrated by the father in the presence of the sibling. Also, there were police reports that indicated the father threatened to harm the sibling.

OCFS Review Results:

Due to concerns learned about the mother's substance misuse, the sibling was removed and placed with a maternal aunt. There were no corresponding progress notes reflecting the filing in family court. The documented telephone call with the father was unclear if the allegations against him were discussed, and the Investigation Conclusion Narrative referenced police reports not otherwise documented in the record (it was documented there were 36 domestic incident reports between the mother and father, but no reference to the father threatening harm to the sibling). This investigation occurred during an open FSS. At closing, the sibling remained in 1017 placement and the FSS remained open.

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

Issue:

Adequacy of Progress Notes

Summary:

It was unknown where information in the Investigation Conclusion Narrative was obtained as it was not documented in progress notes.

Legal Reference:

18 NYCRR 428.5

Action:

ACS will accurately document all casework activity into progress notes.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/10/2023	Sibling, Male, 7 Months	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 7 Months	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 7 Months	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received on 5/10/23 alleged that during the night of 5/9/23, the mother was intoxicated when she walked up to the father's car and threw the sibling at the father, then struck the father twice in the face while the sibling was on his lap. The sibling sustained no injuries. There was a history of violence between the father and mother.

Report Determination: Unfounded | **Date of Determination:** 06/30/2023

Basis for Determination:
Regarding the allegation of Inadequate Guardianship against the mother, ACS determined the father admitted he made a false report against the mother, that she did not physically assault him in the presence of the sibling, nor was the sibling thrown. The allegation of Parent's Drug Alcohol Misuse was unsubstantiated as the mother denied being under the influence, and the father admitted he made a false report, confirming the mother was not under the influence of alcohol or drugs. Inadequate Guardianship was unsubstantiated against the father as the father denied subsequent allegations received during the investigation and the sibling was unable to be interviewed.

OCFS Review Results:
Both parents made law enforcement reports against one another throughout the investigation. Legal was consulted to access family court; however, denied on account of both parents being considered "aggressors" and there being no perceived impact on the sibling. The parents continued to reside separately. The mother was sent for drug screening on 3 occasions and did not comply and was not asked why the screens were missed. The mother agreed to PPRS and an FSS was opened and awaiting agency assignment. The father was engaged over the phone only. The sibling was observed on multiple occasions throughout the 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)
12/03/2022	Sibling, Male, 2 Months	Father, Male, 40 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 2 Months	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Months	Mother, Female, 36 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report received on 12/3/22 alleged that the sibling resided with the mother and father and the mother was using drugs. The mother used cocaine until impaired while in the presence of the sibling. The mother was unable to provide adequate care to the sibling while impaired. The father left the sibling alone with the mother knowing the mother was an inappropriate caregiver due to drug use. The parents engaged in verbal arguments in the presence of the sibling; they

shout and scream at each other and the sibling would cry. Law enforcement has been called to due to the violence in the home.

Report Determination: Unfounded	**Date of Determination:** 01/25/2023

Basis for Determination:
ACS unsubstantiated the allegations and unfounded the report. The Investigation Conclusion Narrative stated ACS did not obtain evidence that would suggest the mother used drugs or alcohol. ACS observed the mother providing proper care for the sibling and was proactive seeking services for the family. The Investigation Conclusion Narrative did not explain how the evidence gathered did not support the allegations.

OCFS Review Results:
It was learned through interviews and collateral contact the allegations were made spitefully. While appropriate to unfound the report based off the information as reported by the mother, father, and collaterals with direct knowledge of the 12/3/22 incident date, there were missed opportunities to further support the determination by contacting EMS and LE, collaterals who were reported to have responded to the 12/3/22 incident as well. At the close of the investigation, the father had left the residence, though maintained telephone/video contact with the mother/sibling. The mother was engaged in parenting, counseling, and housing services. The sibling was assessed safe throughout the investigation.

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

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

The family had additional history with ACS.

In 2012, the mother had an indicated case in which her paramour was substantiated for Lacerations/Bruises/Welts regarding a now adult sibling; however, the mother was unsubstantiated for Inadequate Guardianship and Lack of Medical Care regarding that sibling. An FSS was opened as the mother failed to obtain an Order of Protection to protect the sibling; however, eventually did so and as the mother did not want preventive services, the FSS closed shortly after opening.

In 2020, the mother was substantiated for Inadequate Guardianship and Lacerations/Bruises/Welts regarding a now adult sibling. Both the mother and sibling reported a physical altercation took place, at which time the mother bit the child on the thumb, causing a laceration. At the close of the investigation, the sibling was residing with a maternal aunt and the mother had been referred to community-based services for counseling and parenting skills.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 05/18/2023

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐

Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Preventive Services History

An FSS was opened on 5/18/23, in response to the 5/10/23 CPS investigation. The FSS began as a preventive services case with a contract agency. Concerns arose in February 2024 surrounding the mother's drug use and ongoing interpersonal violence between the mother and father. The sibling was removed and placed pursuant to FCA1017 with a relative. Article 10 petitions were filed and services were ordered (parenting skills, domestic violence counseling/batterer's accountability, random drug screening). Neither parent complied with services; however, the sibling was released to the care of the mother on 9/12/24 with 9 months of ACS supervision. The subject child had been born at that time, but due to his continued hospitalization, was assessed safe until hospital discharge. Upon discharge, ACS was denied an Order of Supervision on the subject child. Home visits were conducted routinely. The last home visit occurred on 1/28/25, just prior to the child's hospital discharge (1/31/25); at which time a crib was observed, along with ample food and no signs of alcohol. The mother declined the next home visit, citing her attorney advised her a visit was unnecessary. The last visit prior to death was on 2/12/25; however, ACS was not allowed inside the home at that time. Safe sleep recommendations were reviewed at that visit. Given both parents' lack of engagement in services, the family court response was concerning.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/29/2024	Not Adjudicated	Adjourned in Contemplation of Dismissal (ACD)
Respondent:	070795 Mother Female 38 Year(s)	
Comments:	On 2/29/24, ACS filed a neglect petition against the parents on behalf of the sibling, following concerns of the mother misusing substances, requiring the administration of NARCAN, and ongoing physical altercations between the mother and father. On 3/1/24, family court issued an Order of Supervision for the mother and sibling and the sibling was directly placed (1017) with a maternal aunt. The mother and father's contact with the sibling was to be supervised. The mother was to engage in a CASAC assessment, cooperate with random drug screenings, engage in preventive services, and complete domestic violence counseling. The father was to also engage in a CASAC assessment, random drug screening, a mental health evaluation, and a batterer's accountability program. On or about 9/12/24, the petition was settled in family court with an ACD for a period of 9 months and the sibling was returned to the mother under ACS supervision despite neither parent completing services.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/06/2025	There was not a fact finding	Withdrawn
Respondent:	070797 Father Male 42 Year(s)	
Comments:	Following the birth of the subject child, ACS conferred with legal services regarding filing derivatively on behalf of the child, as at birth, the sibling remained in 1017 placement and the mother had yet to engage in services. It was decided to file as the child's hospital discharge date approached. The child was discharged home to the mother from the hospital on 1/31/25 and ACS filed in family court on 2/6/25, against the father only. The child was released to the mother and family court issued an Order	

	of Protection on behalf of the child against the father, but allowing for supervised visitation (and despite an extensive history of domestic violence of which neither parent engaged in services for, family court would allow the mother to supervise the father's visits). ACS was not granted an Order of Supervision over the subject child, therefore, ACS only had supervision over the sibling and the mother did not have to produce the subject child for ACS, nor sign releases of information. The record indicated ACS intended to request a meeting with legal following court as there were still concerns.

Have any Orders of Protection been issued? Yes	
From: 02/06/2025	**To:** Unknown
Explain: Upon filing neglect against the father, an Order of Protection was issued on behalf of the subject child against the father, permitting the father supervised contact only.	
From: 09/12/2024	**To:** 06/12/2025
Explain: At the time the mother's 2/29/24 neglect petition was settled with a 9 month ACD on 9/12/24, an Order of Protection was issued on behalf of the mother and sibling against the father. The Order of Protection allowed for supervised visitation with the sibling, and allowed for both parents to see the subject child in the hospital.	

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