Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-020

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

Issue Date: Jul 28, 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: 10 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 02/24/2025
Initial Date OCFS Notified: 02/24/2025

Presenting Information

On 2/24/25, an SCR report was received alleging that on 1/4/25, the subject child went into cardiac arrest while in the care of the father and parent substitute. The parent substitute gave the subject child a bottle around 4:00PM, before putting her in a crib and walking away. Upon return, the parent substitute found the subject child limp and unresponsive. The father was alerted, and the parent substitute started CPR and contacted 911. While administering CPR, milk came out of the subject child's mouth, and the parent substitute turned the subject child over and struck the subject child's head on the floor. EMS arrived at the case address and transported the subject child to the hospital. On arrival, hospital staff found the subject child pulseless with fixed pupils. Life-saving measures continued and the subject child attained consciousness, was placed on life support, and entered the Pediatric Intensive Care Unit (PICU). The subject child arrived at the hospital with bruising and swelling around her eyelids, hyperpigmented scars on her body, and a sewing needle in her right thigh. The subject child had untreated infections, and experienced multiple episodes of cardiac arrest and multi-organ failure while in the PICU. On 2/24/25, the subject child was taken off life support and was pronounced deceased at 1:25PM. The cause of death was cardiac arrest after withdrawing support. The injuries on the subject child were suspicious and the caregivers had no explanation for their cause.

Executive Summary

This report concerns the death of the 10-month-old female subject child that occurred on 2/24/25. When the fatality occurred, the Administration for Children's Services (ACS) had an open CPS investigation and an open family services stage (FSS) due to the emergency removal of the subject child and the 3-year-old other child, the son of the parent substitute. At the time of the subject child's death, she was hospitalized.

The family was known to ACS as there was an open Preventive Services case with court orders that initiated on 4/9/24, after the subject child was removed from the birth mother and placed with the subject father. After 4/9/24, the subject child was removed from the subject father and placed in foster care, then returned to the subject father by the Family Court judge twice prior to the fatal incident. The subject child was last returned to the subject father on 9/13/24, and she moved from the foster home to the subject father's care on 9/16/24.

On 1/4/25, the day of the fatal incident, the subject child was in the care of the parent substitute and the subject father, with whom she and the 3-year-old other child resided. The parent substitute fed the subject child a bottle around 3:00-4:00PM, and put her in the crib to sleep. The parent substitute left the room, and when she returned, the subject child "did not look the right color." The parent substitute picked up the subject child and found her unresponsive and limp. The parent substitute started CPR and called 911. EMS responded to the scene and transported the subject child to the hospital where the subject child was observed to have suspicious bruising and swelling on her head and around her eyes, in addition to other injuries. The subject child was revived in the Emergency Room, and was placed on life-support and admitted to the PICU. The subject child remained on life-support until 2/24/25, when a meeting occurred and the decision was made to remove the subject child from life-support. The subject child's time of death was 1:25PM.

The hospital reported the primary cause of death was cardiac arrest after withdrawing support. The medical examiner was informed, and an autopsy was performed on the subject child. The medical examiner reported the cause of death was listed as unexplained, and the manner of death was pending the final autopsy report. Law enforcement was updated on the

subject child's passing, and the criminal investigation was ongoing when the CPS investigation closed.

ACS made several home visits and conducted limited interviews with the caregivers due to their lack of cooperation. The other child remained in foster care and was assessed as safe in his kinship placement.

ACS made the appropriate determination to substantiate the allegations against the subject father and the parent substitute. A fair preponderance of evidence was obtained that demonstrated their actions and inactions contributed to the subject child's death.

The subject father was offered and declined bereavement services. The case record did not reflect the parent substitute or the subject child's birth mother were offered services in relation to the fatality. The FSS remained open, and the Article 10 neglect petition was pending when the CPS investigation closed.

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

Explain:

ACS appropriately determined the allegations that were received on the intake report from the SCR.

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:
Casework activity was not commensurate with casework circumstances as there was no documentation present in the case record that the birth mother of the subject child, or the parent substitute were offered services in response to the fatality.

Required Actions Related to the Fatality

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

Issue:	Adequacy of services following the fatality
Summary:	There was no documentation present in the case record that demonstrated services related to the fatality were offered to the birth mother or the parent substitute, despite having opportunities to do so before the family members decided to stop communicating with ACS. The case record demonstrated a phone call was made to the birth mother on 2/24/25, and to the parent substitute on 3/18/25. ACS had an opportunity to offer services at these times and did not do so.
Legal Reference:	18 NYCRR 432.2(b)(4);428.6
Action:	ACS will explore areas of potential service needs with all family members with whom they are involved. ACS will appropriately respond to changing circumstances, and if service needs are identified, ACS will make the appropriate referral to community based services in an effort to determine whether there are services that can benefit the family.

Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The case record did not reflect an interview was conducted with the birth mother that contained key safety related questions in an effort to assess safety and risk. The documented conversation was focused on the birth mother's last contact with the subject child and the subject father's substance misuse.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS will incorporate key safety-related questions as they pertain to case circumstances.

Issue:	Failure to provide notice of report
Summary:	ACS did not provide Notice of Existence Letters to the other child's father or the mother's of the subject father's other children.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS will notify the subjects and other adults named in the report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/24/2025 **Time of Death:** 01:25 PM

Date of fatal incident, if different than date of death: 01/04/2025
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: 05:09 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	10 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Other - Parent Substitute	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Child - Parent Sub's child	Alleged Victim	Male	3 Year(s)

LDSS Response

ACS had an open CPS investigation and FSS with the family when the SCR report was received regarding the death of the subject child. Within the first 24 hours, ACS updated law enforcement, informed the DA, conducted home visits, and assessed the other child as safe in the kinship foster home.

ACS interviewed the caregivers regarding the events leading up to the fatal incident. The parent substitute stated she fed the subject child a bottle at approximately 3:00-4:00PM, burped her, and placed her in her crib to sleep. The parent substitute went into the bathroom before she reentered the room to get clothing. The parent substitute stated she looked over at the child and saw she “looked weird," and was “not the right color.” When she touched the subject child, the child did not respond as she normally would. The parent substitute lifted the subject child out of the crib and found she was limp, and placed the subject child on the other child’s bed and began CPR. The parent substitute found the toddler bed was not supportive enough, and the parent substitute moved the subject child onto the floor and continued chest compressions.

The parent substitute stated the subject father contacted 911, and the parent substitute was instructed on how to perform pediatric CPR. The caregivers observed "a lot of milk" come out of the subject child during CPR. The subject father confirmed the account provided by the parent substitute, and stated that he brought the subject child to EMS when they arrived, but did not go to the hospital at that time because the parent substitute was not dressed and they needed to find someone to watch the other child. The caregivers stated the subject child may have obtained the hematoma and black eye when the parent substitute was performing CPR as the parent substitute turned the subject child over to pat her back and may have hit her head on the floor. The other injuries were suggested to have been inflicted by the cat. After the initial interview, the caregivers declined to engage further with ACS.

ACS contacted hospital staff who reported the subject child was admitted on 1/4/25, after she was found unresponsive by the caregivers. The subject child arrived at the hospital with fixed pupils and without a pulse. Lifesaving measures were performed, and she attained consciousness about 15-20 minutes later. It remained unknown when CPR began, or if it continued during transport to the hospital; however, it was believed that the subject child went approximately 30 minutes without oxygen to the brain. The subject child was observed to have suspicious bruising and swelling around her eyelids which appeared inflicted, a laceration to the right eye, hyperpigmented scars on various places on her body, and was discovered to have a foreign body present in her right thigh during a skeletal survey. The subject child was admitted to the PICU, and additional tests conducted revealed the subject child had a hematoma and a bilateral infection of the blood stream. The subject child was placed on a ventilator until 1/14/25, when her condition declined, and she was placed on life support. On 2/19/25, a conference was held with the family, doctors, and ACS, and the decision was made to remove the subject child from life support. On 2/24/25, life support was removed, and the subject child was pronounced deceased at 1:25PM.

ACS interviewed the medical examiner who stated due to the subject child’s hospitalization for 7 weeks prior to death, all findings would be due to secondary complications to what the subject child was admitted to the hospital for. The cause of death was listed as unexplained, and the manner of death was pending the results of the final autopsy report.

ACS interviewed a former daycare provider who reported that on 11/27/24, the subject child was observed to have a large bruise on her face. When questioned, the subject father stated it was due to the subject child teething. The daycare provider requested the caregivers have the subject child seen by a medical provider before she returned to the daycare. The daycare provider followed up with the parent substitute regarding the subject child, and the parent substitute reported “everything was fine;” however, the subject child never returned to the daycare.

A former foster parent was interviewed by ACS. The foster parent stated that when the subject child was returned to the subject father, he contacted her weekly and requested help with medical appointments. The former foster parent and the foster care agency agreed to assist the subject father with scheduling appointments that the subject father would bring the subject child to; however, the foster parent received messages that the appointments were cancelled or the subject father was a no show. The foster care agency confirmed appointments had been scheduled for the subject child on behalf of the subject father for 10/1/24, 11/14/24, and 11/25/24. The subject father failed to bring the subject child to any appointments, and the subject child had not seen a medical provider since being released to her father's care. The foster parent expressed concerns regarding the care provided by the subject. There was no documentation present in the case record that showed these concerns had been conveyed to ACS while the subject child was in foster care, or prior to the fatal incident.

ACS spoke to numerous collateral contacts, including hospital staff, a former daycare provider, a former foster parent, a neighbor, law enforcement and the medical examiner. Concerns were reported regarding ongoing domestic violence between the caregivers, and the subject father appearing under the influence during court appearances and during visits with the subject child at the hospital. At the close of the investigation, the petition filed in Family Court remained pending; however, all previous court orders remained in effect and the FSS remained open due to the other child’s continued placement.

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
070328 - Deceased Child, Female, 10 Month(s)	070469 - Father, Male, 35 Year(s)	Lacerations / Bruises / Welts	Substantiated
070328 - Deceased Child, Female, 10 Month(s)	070468 - Other - Parent Substitute, Female, 24 Year(s)	Lacerations / Bruises / Welts	Substantiated
070328 - Deceased Child, Female, 10 Month(s)	070469 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
070328 - Deceased Child, Female, 10 Month(s)	070469 - Father, Male, 35 Year(s)	Lack of Medical Care	Substantiated
070328 - Deceased Child, Female, 10 Month(s)	070468 - Other - Parent Substitute, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
070328 - Deceased Child, Female, 10 Month(s)	070468 - Other - Parent Substitute, Female, 24 Year(s)	Lack of Medical Care	Substantiated
070328 - Deceased Child, Female, 10 Month(s)	070469 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
070328 - Deceased Child, Female, 10 Month(s)	070469 - Father, Male, 35 Year(s)	DOA / Fatality	Substantiated
070328 - Deceased Child, Female, 10 Month(s)	070468 - Other - Parent Substitute, Female, 24 Year(s)	DOA / Fatality	Substantiated
070476 - Other Child - Parent Sub's child, Male, 3 Year(s)	070468 - Other - Parent Substitute, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
070476 - Other Child - Parent Sub's child, Male, 3 Year(s)	070469 - Father, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
070476 - Other Child - Parent Sub's child, Male, 3 Year(s)	070469 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐
When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
Assessments conducted by ACS, in addition to a history review, demonstrated the caregivers' need for services; however, ACS missed opportunities to offer services to the birth mother, subject father, and parent substitute while they were cooperative. The subject father and parent substitute became escalated with ACS during contacts, and all three caregivers ceased communication entirely. There was no documentation in the case record explaining why referrals were not provided by mail, or other means.
The RAP was incorrectly marked 'no' for question 2, was a child in the care or custody of any substitute caregivers at any time prior to the report, and for question 4, current or recent history of housing with serious heath or safety, unstable/no housing. The subject child was removed from the subject father's care 3 times in 2024, and the subject father was found to be squatting before becoming homeless in a previous investigation. If marked correctly, the overall risk rating would not have changed.

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 1/4/25, which was granted in Family Court on 1/29/25. The other child remained in a kinship foster home when the CPS investigation closed.

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:**
01/08/2025	There was not a fact finding	There was not a disposition
Respondent:	070469 Father Male 35 Year(s)	
Comments:	An emergency removal was conducted on 1/4/25, and a petition was filed in Family Court on 1/8/25. The remand was approved on 1/29/25.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
01/08/2025	There was not a fact finding	There was not a disposition
Respondent:	070468 Stepmother Female 24 Year(s)	
Comments:	An emergency removal was conducted on 1/4/25, and a petition was filed in Family Court on 1/8/25. On 1/29/25, the remand was granted.	

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:
Due to the caregivers' unwillingness to engage with ACS, services related to the fatality were unable to be provided. Consultations were requested for caregivers, and services were offered during consults.

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 other child received services while in Foster Care.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? No
Explain:
Services in response to the fatality were offered to the subject father; however, there was no documentation present in the case record that services were offered to the parent substitute or the birth mother.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections ☐ Had heavy alcohol use

- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Had a positive toxicology at the time of delivery
- ☒ Used marijuana
- ☐ 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)
01/04/2025	Deceased Child, Female, 9 Months	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 9 Months	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - Parent Sub's child, Male, 3 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	
	Other Child - Parent Sub's child, Male, 3 Years	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Other Child - Parent Sub's child, Male, 3 Years	Other - Parent Substitute, Female, 24 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 9 Months	Other - Parent Substitute, Female, 24 Years	Lack of Supervision	Substantiated	
	Other Child - Parent Sub's child, Male, 3 Years	Other - Parent Substitute, Female, 24 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 9 Months	Other - Parent Substitute, Female, 24 Years	Burns / Scalding	Unsubstantiated	
	Deceased Child, Female, 9 Months	Other - Parent Substitute, Female, 24 Years	Internal Injuries	Unsubstantiated	
	Deceased Child, Female, 9 Months	Other - Parent Substitute, Female, 24 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Female, 9 Months	Other - Parent Substitute, Female, 24 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Female, 9 Months	Other - Parent Substitute, Female, 24 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Deceased Child, Female, 9 Months	Father, Male, 35 Years	Lack of Supervision	Substantiated
Deceased Child, Female, 9 Months	Other - Ex-Girlfriend, Female, 34 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 9 Months	Father, Male, 35 Years	Burns / Scalding	Unsubstantiated
Deceased Child, Female, 9 Months	Father, Male, 35 Years	Internal Injuries	Unsubstantiated
Deceased Child, Female, 9 Months	Father, Male, 35 Years	Lacerations / Bruises / Welts	Substantiated
Deceased Child, Female, 9 Months	Father, Male, 35 Years	Lack of Medical Care	Substantiated
Deceased Child, Female, 9 Months	Father, Male, 35 Years	Swelling / Dislocations / Sprains	Unsubstantiated
Deceased Child, Female, 9 Months	Other - Parent Substitute, Female, 24 Years	Parents Drug / Alcohol Misuse	Substantiated
Deceased Child, Female, 9 Months	Other - Parent Substitute, Female, 24 Years	Inadequate Guardianship	Substantiated

Report Summary:
On 1/4/25, the 10-month-old subject child sustained head trauma while in the care of the parent substitute and the subject father. As a result, the subject child was choking, vomiting, and had a large hematoma on her forehead. The subject child had dark bruising and swelling present on her face that resulted in her eyes closing, and a burn on her right hand approximately half an inch in length that appeared to be inflicted.

Report Determination: Indicated

Date of Determination: 03/04/2025

Basis for Determination:
There was a fair preponderance of evidence to substantiate the allegations of IG, LMC, PD/AM, and L/B/W. The subject child was admitted to the hospital where she tested positive for a viral respiratory infection and a bacterial infection, and was found to have a sewing needle embedded in her upper right thigh. Evidence was obtained from a previous daycare provider that showed the subject child with a large bruise on her face prior to being hospitalized. The subject father missed multiple medical appointments, failed to engage in services, and he and the parent substitute failed to submit to drug screenings. The caregivers were arrested for possession on 1/28/25. Allegations of PD/AM and IG were also substantiated against the caregivers in regard to the other child.

OCFS Review Results:
ACS diligently contacted collaterals for updates regarding the case, and reached out to any relevant collaterals in effort to obtain all information possible. Photographs were entered into the case record, and the case notes contained detailed information. The RAP was incorrectly marked 'no' for any child in care or custody of any substitute caregivers at any time prior to the current report date. The subject child was removed from the subject father 3 times in 2024; however, this would not affect the final risk rating. It was unknown why the subject father's ex-girlfriend was added to the report with an allegation listed, in addition to her two children. There was no explanation for the allegations listed against the ex-girlfriend being unsubstantiated in the investigation conclusion. Despite being added to the investigation, there was no documentation in the case record that demonstrated full interviews were conducted to assess safety and risk of the ex-girlfriend and the other children. Additionally, ACS did not address the allegations of the report with the previous partner in an effort to obtain additional information regarding the incident. ACS learned the ex-girlfriend had recently given

birth, and failed to provide safe sleep information. The other child's father was not contacted, nor were efforts to contact him documented in the case record.

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 father's ex-girlfriend, who shared a child with the subject father and had two additional children, was added to the investigation along with two children; however, the case record demonstrated the children were not assessed for safety or interviewed until 3/3/25. The case record revealed the interviews with the ex-girlfriend and the 12 and 10-year-old other children did not contain key safety related questions; there were no full interviews to assess safety and risk. Additionally, despite being added to the report with allegations of Inadequate Guardianship made against her, the case record does not contain documentation that the ex-girlfriend was interviewed regarding the allegations in the report.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

ACS will incorporate key-safety related questions as they pertain to case circumstances; the victim children, any other child listed on a report, and their parents/guardians, should be interviewed prior to closing the investigation.

Issue:

Failure to provide safe sleep education/information

Summary:

While in the home of the subject father's ex-girlfriend, ACS learned the ex-girlfriend had given birth to her third child. Despite being in the home and documenting safe sleep provisions for the infant, there was no documentation that a conversation surrounding safe sleep education/information occurred.

Legal Reference:

13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:

ACS will provide information on sleep safety to the parents and caretakers of infants and parents to be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/08/2024	Deceased Child, Female, 4 Months	Father, Male, 35 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Deceased Child, Female, 4 Months	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 4 Months	Father, Male, 35 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:

The subject father had concerning mental health issues that affected his behavior. The subject father was bipolar; however, he refused to go to therapy or take medication to address the issue. Due to his untreated mental health, the subject child was placed at risk due to the subject father's erratic and aggressive behaviors. On an unknown date, the subject father assaulted the birth mother in the subject child’s presence.

Report Determination: Indicated	**Date of Determination:** 08/19/2024

Basis for Determination:
There was some credible evidence obtained during the investigation to substantiate the allegations against the subject father. On 8/8/24, the subject father arrived at the ACS office with the subject child who was wrapped in a blanket and had no clothing on. The subject father did not have housing; he was considered a squatter and forced out of an apartment. The subject father had a history of substance use and appeared to be under the influence during an encounter with ACS.

OCFS Review Results:
ACS immediately initiated the investigation to assess the safety of the subject child and placed her in foster care. The notes contained detailed information; however, the SCR report has the birth mother listed and she was never interviewed. The case record demonstrated the birth mother may have been mistaken for the subject father's previous partner; however, it was never clarified. The RAP was incorrectly scored for multiple questions, including being marked 'no' for history of domestic violence, and 'yes' for prioritizing the children's needs before his own and understanding the seriousness of potential harm to the child and willing to address areas of concern. Due to this case practice issue being cited in the 6/5/24 investigation, it will not be cited again.

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 BM was listed on the report; however, there were no documented attempts to interview her.

Legal Reference:
18 NYCRR 432.1 (o)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/24/2024	Other Child - Stepbrother, Male, 2 Years	Other - Parent Substitute, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Stepbrother, Male, 2 Years	Other - Parent Substitute, Female, 24 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
The parent substitute was the primary caregiver to the 2yo other child, and on the morning of 6/24/24, the parent substitute left the other child unsupervised. The parent substitute was gone for over an hour and the other child could be heard crying.

Report Determination: Unfounded	**Date of Determination:** 08/23/2024

Basis for Determination:
There was not a fair preponderance of evidence to show the parent substitute failed to provide the minimum degree of care to the other child. The other child was determined to have been at daycare on the day of the alleged incident.

OCFS Review Results:
The safety assessments were adequate, and the daycare was contacted to confirm the other child was in attendance the

day of the alleged incident. There were 5 out of 19 notes entered more than 6 weeks after the event, which included 2 supervisory reviews which were entered a week before the case closed. Safety assessments were completed adequately and on time. There were no documented attempts to contact the father of the other child present in the case record.

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:

There were no documented efforts in the case record of attempts to contact and engage the father of the OC.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

26% of the case notes were entered more than a month late, including a supervisory note which contained directives. This note was entered 1 week prior to the case closing date.

Legal Reference:

18 NYCRR 428.5

Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/05/2024	Deceased Child, Female, 2 Months	Father, Male, 34 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Female, 2 Months	Father, Male, 34 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 2 Months	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 2 Months	Mother, Female, 27 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 2 Months	Mother, Female, 27 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:

The condition of the home was filthy and unsanitary for the then 2-month-old subject child. The home was dirty, there was trash and drug paraphernalia present, and dirty clothing throughout the home. The birth mother abused illegal substances to impairment while caring for the subject child. The subject father was aware, and continued to leave the subject child in her care. There were violent physical altercations between the subject father and the birth mother in the

presence of the subject child, and at times the subject child was in the arms of one of the caregivers when it transpired. The week prior to the report, the subject child hit her head on the wall. LE had been to the home several times to address domestic violence and the birth mother and subject father did not have provisions for the subject child.

Report Determination: Indicated | **Date of Determination:** 07/23/2024

Basis for Determination:
There was some credible evidence that the birth mother misused substances to impairment which impacted her capacity to exercise a minimum degree of care necessary to meet the physical, mental, and emotional needs of a child. The subject child was removed from the birth mother and placed in foster care. During an interview, the birth mother admitted she used an illegal substance, and she tested positive for the substance when a drug screen was completed. The subject father was not engaged in mental health services, and allowed the birth mother to care for the subject child despite the presence of an OP barring her from being around the subject child. Evidence was obtained during the investigation that demonstrated the subject father did not adhere to a minimal standard of care that was consistent with generally accepted societal norms.

OCFS Review Results:
The RAP was incorrectly scored 'no' for domestic violence and the caretaker attended to and prioritized the child's needs despite an incident that took place during the investigation that resulted in both the birth mother and the subject father being arrested. Additionally, the subject father allowed the birth mother to have contact with the subject child despite the presence of an OP.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The Risk Assessment Profile was incorrectly scored 'no' for the presence of domestic violence, despite documentation stating the birth mother and subject father were arrested due to a domestic incident during the investigation. Additionally, the RAP was scored 'no' for prioritizing the subject child's needs before their own, despite the subject father allowing the birth mother to care for the subject child while there was an active, full stay away OP in place to protect the child.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/28/2024	Deceased Child, Female, 1 Days	Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Substantiated	Yes

Report Summary:
On 3/27/24, the birth mother gave birth to the subject child. The birth mother and subject child’s toxicology reports were positive for an illegal substance and marijuana at delivery.

Report Determination: Indicated | **Date of Determination:** 05/09/2024

Basis for Determination:
During the investigation, evidence was obtained to substantiate the allegations of PD/AM against the birth mother in regard to the subject child. The evidence obtained showed the birth mother misused substances to the point where she was unable to provide the subject child with the minimum degree of care to meet their physical, mental, and emotional

needs. The birth mother disclosed marijuana being her preferred substance, and drug testing at the hospital was positive for an illegal substance.

OCFS Review Results:
There was no documentation present in the case record that the subject father was questioned about missing requested drug screens that were a requirement of the custody agreement. Additionally, the subject father was not questioned about the arrest for attempting to sell illegal substances which resulted in probation. The subject father admitted he lied about his mental health, and a HIPAA release was signed; however, there was no information in the case record of the records being obtained to confirm the diagnoses he had received.

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

ACS failed to address key safety related issues with the subject father who was under court orders. During the investigation, ACS was informed the subject father was arrested for attempting to sell illegal substances which resulted in probation, lied about his mental health history, and failed to complete drug screens that were a requirement of the custody agreement. A HIPAA release was obtained; however, there was no follow up with providers to ensure a court ordered mental health evaluation was completed, despite ongoing concerns. ACS's investigation focused on the allegations in the SCR report and failed to assess the subject child's overall safety and risk.

Legal Reference:

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

Action:

ACS will incorporate key safety-related questions as they pertain to case circumstances and will address any new concerns as they arise in effort to assess safety and risk. Prior to making a determination, ACS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/31/2022	Other Child - Stepbrother, Male, 1 Years	Other - Parent Substitute, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
On 7/30/22, the parent substitute was agitated and became aggressive with other adults. The parent substitute had suicidal ideations and required medical attention while the caregiver of the then 1-year-old other child.

Report Determination: Unfounded | **Date of Determination:** 09/07/2022

Basis for Determination:
There was a lack of evidence to substantiate the allegations. It was confirmed the other child was not present for the incident and was in the care of his father. The parent substitute was not under the influence of any substances, and collaterals had no concerns. Announced and unannounced home visits were conducted and resulted in no safety concerns.

OCFS Review Results:
ACS conducted thorough interviews, including speaking to the other child's father who confirmed the other child's whereabouts during the incident. Relevant collateral contacts were made, and the other child was assessed as safe when he was located. The safety assessments were completed timely and adequately.

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.

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?	☒	☐	☐	☐

Required Action(s)

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

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	The case record contained multiple open FSS and CPS investigations open simultaneously that led to fragmented case recording.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS will provide a thorough family assessment and an account of all family and children's services delivered to children and their families through case records maintained in the form and manner and at such times as required by OCFS.

Issue:	Adequacy of case recording in FASP
Summary:	ACS added the subject father and subject child to an FSS that was open for the birth mother. Despite the addition of the subject child and subject father to the FSS, the presence of court orders, and ongoing preventive and foster care services, the Family Assessment Service Plans did not include any information, assessments, or planning for the subject father and the subject child.
Legal Reference:	18 NYCRR 428.6(a)
Action:	ACS will record information gathered about family members in receipt of child welfare services, including preventive services, child protective services, foster care and/or adoption services; assist with evaluations and assessments of the family, assist with determining the family's need for services necessary to achieve the child(rens)'s permanency planning goal; assist with ascertaining family progress in meeting desired outcomes and assist with ongoing planning with the family.

Preventive Services History

On 4/9/24, ACS filed a Neglect petition in Family Court and the subject child was released to the care of the subject father with ACS supervision and court orders. The court orders directed the subject father to complete a mental health evaluation and follow all recommendations including medications, comply with a referral for preventive services and homemaking, if deemed appropriate. ACS made the referrals; however, there was no follow up with providers to ensure a mental health evaluation was completed or to request the results. The subject father did not engage in any services, or submit to any requested drug screens despite the court orders. This case remained open, and the subject child was removed from the subject father's care on 6/7/24.

On 6/28/24, the subject child was released to the subject father with temporary supervision of ACS. The subject father was ordered to obtain a mental health evaluation and abide by the results of the assessment, including any prescribed medications. The subject father was directed to follow any recommendations for services, including homemaking and preventive services. Additionally, the subject father was informed that only individuals cleared by ACS were allowed to provide care to the subject child, and the OP was to be followed by everyone living in the home.

On 8/8/24, the subject child was removed from the subject father's care and a 1028 hearing was requested. It was confirmed the subject father started the intake process for a substance abuse program, and he was ordered to participate in anger management, parenting classes, and obtain a mental health evaluation. On 9/13/24, the subject child was released to the subject father with court ordered services which included conditions. The subject father was to enter a shelter with the subject child, engage in substance abuse services, comply with random drug screens, complete a mental health evaluation, and comply with ACS supervision which included home visits. The subject father was unable to be located following the subject child’s release to his care, and he left 4 shelter placements and did not return. The case record demonstrated that ACS made diligent efforts to locate the subject child and subject father by contacting a multitude of collaterals to obtain information regarding their whereabouts. On 10/18/24, the subject father contacted ACS and updated his phone number and reported he and the subject child would be returning to a shelter. On 10/21/24, the subject father's ex-girlfriend brought the subject child to the ACS office and the subject child was assessed as safe. On 10/25/24, ACS learned the subject father and subject child were staying with the subject father's ex-girlfriend, and a home visit was conducted on 10/29/24. Once the family was located, ACS was able to establish regular casework contacts. The subject father engaged in substance abuse services but was at risk of being discharged from the program on two occasions for having intervals of unexplained absence. The case record was unclear regarding what programs the subject father had engaged in at the facility, and showed the subject father did not obtain a mental health evaluation despite ongoing concerns; however, ACS confirmed he was engaged in group counseling sessions. ACS made adequate casework contacts; however, there was no information in the case record of any health information for the subject child.

Foster Care at the Time of the Fatality

The deceased child(ren) were in foster care at the time of the fatality? Yes

Date deceased child(ren) was placed in care:

Date of placement with most recent caregiver? 01/04/2025

How did the child(ren) enter placement? Emergency removal without Court Order

Review of Foster Care When Child was in Foster Care at the time of the Fatality

	Yes	No	N/A	Unable to Determine
Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?	☒	☐	☐	☐
Did the placement comply with the appropriateness of placement standards?	☒	☐	☐	☐
Was the most recent placement stable?	☒	☐	☐	☐
Did the agency comply with sibling placement standards?	☐	☐	☒	☐
Was the child AWOL at the time of death?	☐	☒	☐	☐

Visitation

	Yes	No	N/A	Unable to Determine
Was the visitation plan appropriate for the child?	☐	☐	☒	☐
Was visitation facilitated in accordance with the regulations?	☐	☐	☒	☐
Was there supervision of visits as required?	☐	☐	☒	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource made with required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource in the parent/relative/discharge resource's home made with required frequency?	☒	☐	☐	☐
Were all of the casework contact requirements for contacts with the caretakers made, including requirements for contact at the child's placement location?	☒	☐	☐	☐

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the agency provide the foster parents with required information	☐	☐	☒	☐

regarding the child's health, handicaps, and behavioral issues?				
Did the provider comply with discipline standards?	☐	☐	☒	☐
Were the foster parents receiving enhanced levels of foster care payments because of child need?	☐	☐	☒	☐
If yes, was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	☐	☐	☒	☐
Was the certification/approval for the placement current?	☐	☐	☒	☐
Was a Criminal History check conducted? Date:	☐	☐	☐	☒
Was a check completed through the State Central Register? Date:	☐	☐	☐	☒
Was a check completed through the Staff Exclusion List? Date:	☐	☐	☐	☒

Additional information, if necessary:
The foster care case remained open due to the other child's placement. After the subject child's removal, she remained

hospitalized and died prior to placement in a certified foster home; therefore, certifications/checks/approvals related to the provider oversight and training were not yet required.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☒Yes ☐No

Issue:	Failure to Complete a Plan Amendment
Summary:	A plan amendment was not completed following the fatality. The purpose of a plan amendment is to describe/document significant changes in the status of a case and direct a reassessment so that any necessary revisions to the service plan can be made.
Legal Reference:	18 NYCRR 428.7
Action:	ACS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Foster Care Placement History

On 4/5/24, the subject child was removed from the care of the birth mother and entered foster care while kinship resources were sought. The subject child was released to the care of the subject father on 4/11/24, with court ordered supervision.

On 6/7/24, the subject child was removed from the care of the subject father after it was revealed the birth mother was present in the home despite an OP, and a physical altercation took place between the subject father and birth mother in the presence of the subject child. The caregivers were arrested for domestic abuse and robbery; the birth mother was detained for assaulting the subject father the year prior. The subject child was placed with a family resource and ACS showed cause for the removal; however, the subject child was returned to the care of the subject father on 6/28/24, with court ordered services.

On 8/8/24, the subject child was removed from the care of the subject father when he arrived at ACS with the subject child wrapped in a blanket without any clothing on, and he appeared to be under the influence of a substance. Additionally, the subject father behaved erratically, leading to increased concerns regarding his mental health. The subject father was unhoused and lacked provisions for himself or the subject child, and it was determined he was squatting in his apartment building. An Article 10 Neglect petition was filed in Family Court. Despite the subject father’s pattern of not engaging with or following through with court ordered services, Family Court released the subject child to the subject father's care on 9/16/24, with court orders instructing him to obtain emergency housing with the subject child and engage in services.

On 1/4/25, an emergency removal was conducted for the subject child and the other child after the subject child was found unresponsive in the home and arrived at the hospital with head trauma, dark bruising, and swelling around her eyes. The subject father and parent substitute did not have an explanation for the subject child's injuries, which resulted in the removal of the subject child and the other child. An Article 10 Neglect petition was filed, and on 1/29/25, the remand was granted in Family Court. The other child was placed in kinship foster care with his maternal grandparents. The subject child remained in the hospital on life support.

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