Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-027

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

Issue Date: Aug 12, 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
Jurisdiction: Kings
Date of Death: 03/16/2025
Age: 2 month(s)
Gender: Male
Initial Date OCFS Notified: 03/16/2025

Presenting Information

An SCR report was received that alleged on 3/16/25, the subject mother fed the 2-month-old subject child at 8:00AM. The mother then left him without supervision for an unknown amount of time. The subject child was later found unresponsive by an unknown individual with blood coming out of his nose. An unknown individual performed cardiopulmonary resuscitation (CPR) and then called 911. Emergency Medical Services (EMS) arrived at 9:00AM and attempted CPR yet were unable to resuscitate him. The subject child was then transported to the hospital where he was pronounced deceased on arrival. The subject child was an otherwise healthy child, and the mother had no explanation for his death.

Executive Summary

This report concerns the death of the 2-month-old male child that occurred on 3/16/25. The New York City Administration for Children's Services (ACS) received two SCR reports, on that same date regarding the fatality. The SCR reports contained allegations of DOA/Fatality, Inadequate Guardianship, Inadequate Food/Clothing/Shelter and Lack of Supervision. In addition, the allegation of Inadequate Guardianship and Inadequate Food/Clothing/Shelter was listed against the subject mother regarding the 2-year-old surviving sibling. At the time of his death, the subject child resided in a shelter with his mother and surviving sibling. There was a 14-year-old sibling who resided in another county with her guardian (OA). The subject child's biological father was incarcerated and had never met the child. ACS immediately initiated their investigation and removed the 2-year-old surviving sibling from the mother's care.

Through a joint investigation with law enforcement, it was learned on 3/16/25, the subject child was in the subject mother's care. Around 8:30AM, the subject mother found the subject child bleeding from his nose and unresponsive on the bed. The mother went to get help from shelter staff and 911 was contacted. Emergency medical services responded to the home and initiated life-saving measures. The subject child was transported to the hospital where life-saving measures continued; however, were unsuccessful. The subject child was pronounced deceased at 9:48AM on 3/16/25.

ACS spoke with the medical examiner's office and learned an autopsy was performed on 3/17/25. Hospital staff reported the cause of death being related to unsafe sleep conditions; however, the medical examiner determined it was "too early to rule that as a finding." In addition, the medical examiner explained the subject child had a skeletal survey and CT scan which were unremarkable. There were no concerns for his development, or his weight. At the time ACS closed their CPS investigation, the final autopsy was pending further studies.

The Office of Children and Family Services received the final autopsy report. The subject child's cause of death was sudden unexplained infant death (extrinsic and intrinsic factors identified), and the manner of death was undetermined.

ACS communicated with law enforcement and learned their criminal investigation was still open and was anticipated to close with no criminal charges against the mother, as there was no suspicion of trauma or injury to the subject child. In addition, ACS discussed concerns regarding the mother impersonating district agency staff; however, law enforcement did not report any information to suggest the mother would be criminally charged for her concerning behavior.

ACS substantiated the above referenced allegations against the subject mother regarding the subject child and surviving

sibling. The allegation of Lack of Supervision was unsubstantiated against the mother as she was present with the subject child when he experienced his medical emergency and sought assistance from shelter staff. The 24-Hour and 30-Day Fatality reports were completed timely. Safety Assessments were completed timely and with accuracy, and the Risk Assessment Profile was consistent with case circumstances. ACS gathered information from collateral contacts such as law enforcement, the district attorney's office, EMS, hospital staff, shelter staff, neighbors, the family, and the medical examiner's office. Bereavement services and burial assistance were discussed; however, it remained unknown if the mother utilized the services.

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 made an appropriate decision to substantiate the allegations of DOA/Fatality, Inadequate Guardianship and Inadequate Food/ Clothing/ Shelter. In addition, ACS appropriately unsubstantiated the allegation of Lack of Supervision.

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

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

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

Explain:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/16/2025 **Time of Death:** 09:48 AM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

On 3/16/25, ACS received two SCR reports regarding the death of the SC which occurred on that same date. ACS initiated

their investigation within 24 hours, notified the DA, communicated with the ME, and coordinated their efforts with LE. ACS contacted the sources of the report, completed a CPS history check, and immediately assessed the SS. The SS was removed from the mother's care and placed in a non-familial foster home.

ACS completed an interview with the SM. During her interview, she explained she woke at 6:00AM and fed the SC formula, with a "pinch" of Gerber cereal. After the feeding, she burped him, changed his diaper and laid him on his back on top of a pillow next to her in the bed. The mother confirmed she shared a bed with the SC and woke around 8:30AM. She noticed he was not breathing, and he had mucus with blood coming out of his nose. The mother noted she found the SC in the same position on the pillow, face-up. She reported the SC's color was normal and he felt warm to touch. The mother reported she ran out of the room with the SC to the security officers and asked for help. Life-saving measures were attempted by shelter staff, EMS, and hospital staff but all were unsuccessful. The SM explained days prior to the fatality the SC had a chest cold. She could hear rattling in his chest, and he would breathe through his mouth.

ACS spoke to the maternal aunt regarding the incident. The aunt explained the day prior to the fatality, the mother and children were at her residence and left around 7:00PM. She denied that the SC had any medical conditions; however, did report he had a cold. The maternal aunt reported the mother took good care of the children.

ACS spoke with LE who responded to the 911 call at the shelter. Upon arrival, EMS was already present and later transported the mother and SC to the hospital. The mother reported feeding the SC at 6:00AM, noting he was fine, and they went back to sleep. Around 8:30AM, the mother woke and found the SC unresponsive with blood coming from his nose. The mother yelled out for assistance, and someone contacted 911. It was noted there were no concerns for trauma or injuries to the child. LE observed the mother's unit in "bad condition," and noted there were roaches all over the room, food on the bed and floor, clothing in the cribs, and trash everywhere. In addition, marijuana was observed in the unit accessible to the children.

ACS spoke with shelter staff regarding the incident and learned around 8:55AM, the mother sought assistance from the shelter's security officers due to finding the SC unresponsive and not breathing. The security officers initiated CPR and found a pulse. Additionally, security and EMS attempted to use a defibrillator, and it advised "not to shock." When asked what the mother reported happened, shelter staff explained the mother woke at 6:00AM to feed the SC. After the feeding, the mother laid the SC down on the bed on top of a pillow and slept on the bed with the child. When the mother woke around 8:30AM, she observed the SC unresponsive with blood coming from his nose. Shelter staff clarified that the mother did not leave the SC unattended in the unit or leave the room until she asked for assistance. In addition, the SS was not present and was being cared for by a relative at the time of the incident.

The SS was removed from the SM's care and placed in a non-familial foster home. The investigation was closed timely, and the family's case remained open for foster care services.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: From a medical cause

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
071799 - Deceased Child, Male, 2 Month(s)	071801 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071799 - Deceased Child, Male, 2 Month(s)	071801 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
071799 - Deceased Child, Male, 2 Month(s)	071801 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071799 - Deceased Child, Male, 2 Month(s)	071801 - Mother, Female, 30 Year(s)	Lack of Supervision	Unsubstantiated
071800 - Sibling, Male, 2 Year(s)	071801 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071800 - Sibling, Male, 2 Year(s)	071801 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	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	☒	☐	☐	☐

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:
On 3/17/25, the SS was removed from the mother's care and placed in a non-familial foster home.

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:**
03/18/2025	There was not a fact finding	Article 10 Remand
Respondent:	071801 Mother Female 30 Year(s)	
Comments:	On 3/17/25, the 2yo SS was removed and placed in a non-kinship foster home due to the conditions of the home and mental health/substance abuse concerns. On 3/21/25, Family Court ordered a remand for the SS and the case remained ongoing.	

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

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

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

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The surviving sibling was receiving foster care related services.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The mother was offered bereavement services and burial assistance. It remained unknown if she utilized said services.

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
- ☐ 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)
12/29/2024	Sibling, Male, 1 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report was received that alleged on 12/28/24, the SM gave birth to the SC. The SM was unable to care for the 1yo SS and unable to make an alternate plan of care for the SS. As a result, the child needed protection.

Report Determination: Unfounded | **Date of Determination:** 02/27/2025

Basis for Determination:
ACS unsubstantiated the allegation of IG against the SM regarding the then 1yo SS. The SM gave birth to the SC at her home and was later taken to the hospital. The SM did not have anyone she trusted available to care for the SS, so she took the SS to the hospital with her. The birth was unplanned as the SM expected to give birth at the hospital not at her residence.

OCFS Review Results:
ACS immediately initiated their investigation, spoke to the source of the report and completed a CPS history review. Required notices were provided. Safe sleep was discussed and a voucher for childcare was provided to the mother. Biological fathers were added to the case; however, there were no attempts to notify or interview the parents.

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:
ACS added the biological fathers of the subject child and surviving sibling. Despite this, there were no attempts to locate or interview the parents.

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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/25/2024	Sibling, Male, 1 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Male, 1 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received that alleged on 5/24/24 at 4:15AM, the SM who was recently homeless was found unresponsive on a train with a blanket over her head while the 1yo SS was sitting next to her in a stroller. The child was not being adequately supervised.

Report Determination: Unfounded	**Date of Determination:** 07/23/2024

Basis for Determination:
ACS did not find a fair preponderance of evidence to substantiate the allegations as they did not find the SM to be neglectful and observed that she had stable housing.

OCFS Review Results:
ACS immediately initiated their investigation, spoke to the source of the report and completed a CPS history review. An interview was completed with the mother. The Risk Assessment Profile was not consistent with case circumstances (DV); however, despite the RAP being inaccurate, ACS offered the SM preventive services. The mother identified the biological father of the SS; however, there was no attempt to contact or notify the father. Safe sleep was discussed, and the case was closed timely.

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 inaccurate as the mother had been a victim of abusive and threatening incidents with partners and other adults in the family/neighborhood.

Legal Reference:

18 NYCRR 432.2(d)

Action:

ACS will accurately reflect the current caretakers of children in risk assessments and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/22/2024	Sibling, Female, 14 Years	Other Adult - BF of the 11-month-old sibling. , Male, 33 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 11 Months	Other Adult - BF of the 11-month-old sibling. , Male, 33 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report was received that alleged the SM previously resided in the home with the then 14yo and 11-month-old SSs. The OA2 (BF of the 11-month-old SS) had been trafficking the mother until she and the children were able to escape the home on or around 2/23/24. The criminal activity grossly compromised the safety and wellbeing of the children.

Report Determination: Unfounded	**Date of Determination:** 05/09/2024

Basis for Determination:
ACS unsubstantiated the allegation of IG against the OA2 regarding the 14yo and 11-month-old SS. ACS was unable to ascertain the family's location; however, the 14yo SS was located residing with the OA (guardian of the 14yo SS).

OCFS Review Results:
ACS immediately initiated their investigation and made several attempts to speak to the source of the report. A CPS history check was inaccurate as there was an open investigation at the time that was not documented. Multiple attempts were made in attempts to locate the family. ACS made contact with the SM via phone who denied the allegations and

agreed to meet ACS; however, did not follow through. The 14yo SS's whereabouts were ascertained but there was a missed opportunity for her to be observed, interviewed regarding the allegations, and her living conditions assessed; despite there being an open investigation with cross districts (Erie County Department of Social Services and ACS).

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 14yo SS's whereabouts were ascertained and it was learned she was residing in another county. Despite this, ACS did not attempt to contact child welfare services in the county where the SS resided, to attempt to interview the child to gather information and assess the child's living conditions.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

ACS will make 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/14/2024	Sibling, Female, 14 Years	Grandparent, Female, 62 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Female, 14 Years	Grandparent, Female, 62 Years	Lack of Medical Care	Unsubstantiated	
	Sibling, Female, 14 Years	Mother, Female, 30 Years	Educational Neglect	Substantiated	
	Sibling, Female, 14 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 14 Years	Mother, Female, 30 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 14 Years	Mother, Female, 30 Years	Lack of Medical Care	Substantiated	

Report Summary:

Erie County Department of Social Services (ECDSS) received an SCR report that alleged the OA had custody and had raised the then 14yo SS. In December of 2023, the OA sent the SS to the SM for a visit with the SM and family. The SM had mental health conditions that impaired her parenting skills around the child. The mother was moving from place to place, unable to provide a stable home for the child. She left the child in the care of others. The SM refused to send the SS back to the OA's home. A subsequent report was received that alleged the SS missed 17 days of school and the MGM and SM were made aware but failed to intervene.

Report Determination: Indicated

Date of Determination: 04/22/2024

Basis for Determination:

ECDSS substantiated the allegations of IG, EdN, IF/C/S, and LMC against the SM. The SM encouraged the SS to move to New York City with her. The SM enrolled the SS in school; however, the SS did not regularly attend or receive her required educational services. The SM did not have housing and left the child at the MGM's home with no plan for her

care or necessities. The home conditions were unsanitary. The OA paid for a bus ticket for the SS to return to her residence in Erie County. The SM did not take the SS to the station or provide her with any money, food, or clothing. The SM threw all the SS's clothing away. The SS was eventually returned to the OA's home and was enrolled in school.

OCFS Review Results:
ECDSS initiated their investigation within 24 hours, spoke to the source of the report, and completed a CPS history review. ECDSS worked in conjunction with ACS as they had a secondary role on the investigation. ECDSS and ACS made efforts to interview the SM but were unsuccessful. Safety Assessments were completed timely; however, the investigation determination safety decision was a #3 indicating that a safety plan was in place and that the child was in immediate impending danger and then the case was closed. The case record did not document a safety plan being implemented. The Risk Assessment Profile was consistent with case circumstances and sufficient collaterals were contacted.

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

ECDSS selected safety decision #3 for the investigation determination Safety Assessment indicating that the SS was in immediate or impending danger. The investigation was closed with a safety plan in place; however, there was no documentation in the case record of there being a safety plan.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

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

ACS requested a records check for child welfare history in the states of California, Colorado and Ohio. It remained unknown if there was CPS history outside of NYS.

Legal History Within Three Years Prior to the Fatality

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

Additional Local District Comments

We appreciate the opportunity given us to review the draft report in advance. With respect to the citation issued to Erie

County Department of Social Services regarding the investigation conducted on 2/14/24, we unfortunately must concur with the compliance issue cited by the reviewer. As a corrective action plan, ECDSS will reinforce with CPS team leaders that accurate safety decisions are documented at the investigation determination.

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