Child Fatality Report

Report Identification Number: NY-25-044

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

Issue Date: Sep 23, 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 Grandmother	MGF-Maternal Grandfather	FF-Foster Father
PGM-Paternal Grandmother	PGF-Paternal Grandfather	DCP-Day Care Provider
MGGM-Maternal Great Grandmother	MGGF-Maternal Great Grandfather	PGGF-Paternal Great Grandfather
PGGM-Paternal Great Grandmother	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-Caseworker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 04/27/2025
Initial Date OCFS Notified: 04/27/2025

Presenting Information

On 4/27/25, around 8:00AM, the grandmother checked on the 2-year-old subject child, who was asleep in a crib. The grandmother found him unresponsive, stiff and purple. The grandmother removed the subject child from the crib and placed him on the floor, then began performing cardiopulmonary resuscitation (CPR). The grandmother called 911. The mother was present; however, it was unknown what actions she took during this time. The subject child was transported to the hospital, where he was pronounced deceased at 8:48AM. The subject child was an otherwise healthy child, and the mother and grandmother did not have an explanation for his death.

Executive Summary

The New York City Administration for Children's Services (ACS) received an SCR report regarding the death of the 2-year-old male subject child. When the subject child did not wake up in the morning, the subject maternal grandmother went to check on him and found him unresponsive on the foldable mattress on the subject mother's bedroom floor.

At the time of the subject child's death, he resided with the subject father, the paternal grandparents and the 1-year-old surviving sibling. The 4-year-old surviving sibling resided with her father at their respective residence. The three oldest surviving siblings, ages 10, 8 and 5 years, resided with the subject mother and the maternal grandmother at their respective residence. The fatal incident occurred at the subject mother's home while the subject child and all 5 surviving siblings were present. The father of the 10 and 8-year-old surviving siblings was incarcerated, and the father of the 5-year-old surviving sibling was not identified. The subject mother was pregnant at the time of the fatal incident.

At the time of the fatal incident, a CPS investigation and a preventive services case were already opened, and the subject mother was under ACS supervision due to an Article 10 neglect petition that had been filed due to concerns for the SM's mental health, the condition of the home, and educational neglect. A court order of supervision was in place until July 2025.

ACS spoke with the medical examiner, who confirmed the autopsy was completed on 4/28/25. Preliminary findings did not indicate trauma; however, the medical examiner commented that they believed the death was suspicious due to the family's history with ACS and not having a definitive cause of death. The medical examiner reported there were some discrepancies that suggested a different time of death than the one provided by the subject mother. The final autopsy report documented the cause and manner of death as undetermined.

When ACS spoke with law enforcement, they reported the criminal investigation remained open and they were waiting for the medical examiner's report. There was no further communication with law enforcement.

ACS appropriately determined the allegations. ACS received conflicting information from collaterals regarding the subject mother's account of events; however, there was no documentation of ACS discussing the conflicting information with the subject mother. A safety plan was documented in the Safety Assessments; however, there was no documentation that the plan was discussed with the family. Not all of the fathers were identified, added or contacted and the subject father had two person IDs in CONNECTIONS that were not merged. Additionally, on the last visit to the case address, ACS documented the home was deplorable; however, ACS left the children in the residence with no further action.

ACS provided the family with assistance for the funeral expenses and completed a mental health referral for the 4-year-old surviving sibling; however, it did not appear ACS provided the subject mother, subject father, the grandparents or the surviving siblings with resources for bereavement services. ACS visited all the homes and spoke with the family members.

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:

Prior to the fatality investigation there was a preventive services case opened, and it remained open at the time of this writing.

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:

ACS did not attempt to contact all the BFs and did not add all the BFs to the case. At the last home visit ACS documented the home was deplorable; however, left the children there and did not document further action.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	A safety plan was documented in the Safety Assessments that was not discussed with the family. The CHN were left in a deplorable home. A SS was placed in the care of the BF without a sex abuse allegation being addressed.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS will document all applicable actions and considerations with respect to safety planning, including all family members when devising the plan; adequately monitoring the plan; and consulting the legal department if there is reason to believe the safety plan may not be sufficient. ACS shall include an assessment of the current safety and risk of future abuse and maltreatment to the child(ren).

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/27/2025 **Time of Death:** 08:48 AM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 08:11 AM
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

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 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	63 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	70 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	55 Year(s)
Other Household 1	Mother	Alleged Perpetrator	Female	32 Year(s)
Other Household 1	Sibling	Alleged Victim	Male	10 Year(s)
Other Household 1	Sibling	Alleged Victim	Male	8 Year(s)
Other Household 1	Sibling	Alleged Victim	Male	5 Year(s)
Other Household 2	Other Adult - 4yo SS's BF	No Role	Male	32 Year(s)
Other Household 2	Sibling	Alleged Victim	Female	4 Year(s)

LDSS Response

ACS determined the 4yo and 1yo SSs were safe in the care of their fathers. At the close of the investigation, there were ongoing concerns for the 3 oldest SSs in the care of the SM, and ACS planned to file another Article 10 neglect petition.

The SM reported the night of the fatal incident, she and the CHN were in her bedroom. Between 11:30PM and 12:30AM the CHN fell asleep. The SC was sleeping on the SM's bed, and she moved him to the mattress on the floor. She then placed blankets over the CHN. The SM woke before 8:00AM and began preparing breakfast. When the MGM woke, she checked on the SC and found him unresponsive. The SM observed the SC to be purple. She called 911, EMS arrived and transported the SC to the hospital, where he was pronounced dead. The SM disclosed the SC previously had neurological events, was taken to the hospital for treatment and was not on medication. She explained the SF did not take the SC for a necessary sleep study. The SM stated the SC had a neurological event about 1-2 months prior.

The MGM reported she arrived home around 12:30AM, and the CHN were asleep except the 1yo SS. She did not check on the CHN because she did not want to wake them. Around 8:20AM, the SM stated she could not believe the SC was still sleeping, and the MGM asked if he was sick, and the SM stated no. The MGM checked on the SC, noticed his lips were purple, and she began CPR while the SM called 911. She stated the SC's teeth were clenched, and his hand was in a fist. Later, the MGM reported she thought the SC died of a neurological event. She stated that to her knowledge, the SC had experienced 7 or 8 neurological events.

The SF reported he dropped the SC and 1yo SS off to the SM on 4/26/25 at 3:34PM. He received a call on 4/27/25 from the SM stating the SC had a neurological event and did not make it. The SF stated the SC had two previous neurological events, the first on 03/12/25 and the second in April 2025. He noted the SC was supposed to have an electroencephalogram (EEG) that was not scheduled. Later, the SF stated, the SC had experienced 5 or 6 neurological events while in his care. The SF was able to describe in detail how the SC's body looked during a neurological event.

The PGM said, "There may be some foul play." She stated the neighbor reported hearing a child crying and banging the night of the fatal incident. ACS confirmed this account of events with the neighbor. Later, the PGM stated while at the hospital, they were told the SC was in advanced rigor mortis, and she believed the SC did not die when the SM reported he did. To her knowledge, the SC experienced neurological events prior to the fatal incident. The PGM noted she believed the

SC was crying, and it triggered the SC to have a neurological event, and the SM did not seek medical attention.

The 4yo SS's BF reported the SM did not seek medical attention for the SC after he had a neurological event the night he passed away. He stated he was aware of this information because he overheard the SM state, "it was my fault", and the MGM state "she wasn't taking care of him right that day", in reference to the SM caring for the SC the night of the incident. On another occasion, he reported he overheard the MGM tell the SF the SC had a neurological event the night prior to his death between 10:00 and 11:00PM.

The SM told her MH provider that she noticed the signs of the SC having a neurological event at the time of the fatal incident, and she called 911.

The neurologist first attended to the SC on 5/16/24. The SC was recommended for a follow-up appointment due to being high risk. Medical records reflect he missed three appointments following his initial visit. It was recommended the SC have an EEG to classify the disorder; however, the SF refused. The neurologist stated, had he been aware of the frequency the neurological events he would have pushed for the EEG and admitted the SC to the hospital due to the life-threatening risk.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or 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
071813 - Deceased Child, Male, 2 Year(s)	071816 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
071813 - Deceased Child, Male, 2 Year(s)	071816 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
071813 - Deceased Child, Male, 2 Year(s)	071817 - Grandparent, Female, 55 Year(s)	DOA / Fatality	Unsubstantiated
071813 - Deceased Child, Male, 2 Year(s)	071817 - Grandparent, Female, 55 Year(s)	Inadequate Guardianship	Substantiated
071813 - Deceased Child, Male, 2 Year(s)	071815 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated

071813 - Deceased Child, Male, 2 Year(s)	071815 - Father, Male, 32 Year(s)	Lack of Medical Care	Substantiated
071814 - Sibling, Female, 1 Year(s)	071816 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
071818 - Sibling, Male, 10 Year(s)	071816 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
071819 - Sibling, Male, 8 Year(s)	071816 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
071820 - Sibling, Male, 5 Year(s)	071816 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
071821 - Sibling, Female, 4 Year(s)	071816 - Mother, Female, 32 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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?	☐	☒	☐	☐

Explain:
Records indicated that the 4yo SS's BF was charged with rape 3 and sex abuse-3rd: subject another person to sex contact without consent. He was sentenced to 6 years of probation. ACS placed the SS in his care without explanation as to how it was determined the SS was safe in his care.

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The SM was uncooperative and refused resources and services. ACS documented that they planned to file an additional Article 10 neglect petition against the SM to continually assess the safety of the SSs that were in her care.

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?	☐	☒	☐	☐

Explain as necessary:
ACS documented that they planned to request a removal of the SSs that remained in the SM's care. At the time of case closure, the MGM remained in the home to supervise the SM with the children.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

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:
A preventive case was already opened. The SM was already enrolled in MH and substance abuse treatment. One SS was provided with a MH referral. No other family members appeared to be provided with bereavement resources. ACS provided funeral assistance.

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? No
Explain:
ACS completed a MH referral for one of the SSs. It did not appear that ACS offered the family resources for the other SSs to engage in MH or bereavement 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:
ACS provided financial assistance for the SC's funeral; however, it did not appear bereavement resources were provided to the SF or grandparents. The SM was already engaged in MH treatment.

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

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)
04/21/2025	Sibling, Male, 10 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 5 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	

Report Summary:
On a regular basis, the mother would scream and yell at the children in the home. The mother could be heard striking the children in the home, and the children would cry and scream. On 4/21/25, a child called the mother a name, and the

mother started to yell and scream at the children. A slapping sound could be heard. It was unknown if the children sustained any physical injuries. On 4/27/25, around 8:00AM, another SCR report was received concerning the death of the SC and the allegations were investigated in a separate investigation.

Report Determination: Indicated	**Date of Determination:** 06/20/0205

Basis for Determination:
ACS indicated the allegations of IG against the SM regarding the 10, 8 and 5yo. There was a fair preponderance of evidence to support the allegations. A collateral source reported the SM would yell at the children repeatedly and often used profanity. The SF and 4yo SS's BF expressed concerns for the SM's MH and worried for their childrens' safety. The SM had been found to be unable to manage her emotions and would become combative with service providers. The agency tried to provide services to the SM, and she was unwilling to accept the services.

OCFS Review Results:
The SM was interviewed. The SSs, SF, MGM and other BF were asked about the allegations; however, not fully interviewed. While the investigation was open, the SC died, and the death was investigated separately. The progress notes had gaps that did not explain ACS being notified of the fatal incident. There were no details surrounding events prior to ACS interviewing the SSs regarding the SC's death. There was an active preventive case open and an Article 10 neglect petition.

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:

Conversations with SF, MGM, other BF, and SSs were lacking key safety-related questions; there were no full interviews to assess overall safety and risk. The fathers, MGM, and SSs were interviewed about allegations only. Not all BF's were added, notified and contacted.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

ACS will make casework contacts per 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)
02/06/2025	Sibling, Male, 10 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 8 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 5 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	

Sibling, Female, 1 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 8 Years	Mother, Female, 32 Years	Lack of Medical Care	Unsubstantiated
Sibling, Male, 5 Years	Mother, Female, 32 Years	Lack of Medical Care	Unsubstantiated
Sibling, Female, 1 Years	Father, Male, 32 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 1 Years	Father, Male, 32 Years	Lack of Medical Care	Substantiated

Report Summary:
The then 8 and 5yo SSs had ongoing behavioral and MH concerns. The 8yo SS exhibited defiant behaviors towards adults and inappropriate behaviors towards peers. The 5yo SS had expressed self-harming behaviors on multiple occasions, was physically aggressive towards peers, touched other children in an inappropriate manner and exhibited emotional lability. The mother failed to adequately address the concerns. Two more SCR reports were received alleging that the SM threw one of the children against the wall, that the SM would yell at and hit the children and that the SM was heard saying she was going to “smack the shit out of you” to the children.

Report Determination: Indicated | **Date of Determination:** 04/07/2025

Basis for Determination:
ACS substantiated the allegations of IG against the SM regarding all the children, substantiated the allegations of IG and LMC against the SF regarding the then 1yo SS and unsubstantiated the allegations of LMC against the SM. ACS learned the SM was not meeting the children's basic needs. She failed to follow through with service referrals and recommendations for the children and was violent towards others in the presence of the children. The 1yo SS had a burn mark that the SM and SF had conflicting stories about. The SS missed her follow-up appointment with a child abuse specialist. A court order of supervision was in place until July of 2025, and the SM had supervised visits.

OCFS Review Results:
ACS began their investigation within 24 hours, contacted the sources, and completed a CPS history review. The investigation was thorough, involving family contacts, diligent collateral contacts, a school meeting, detailed supervisory notes and legal consults. Safety Assessment decisions were appropriate, the RAP was accurate, progress notes were timely and detailed, resources were provided, and the case was closed timely. A Safety Factor in the Initial Safety Assessment was documented incorrectly. There was no attempt to contact a BF, and the 4yo SS was not fully interviewed. CAC interviews were not completed, and ACS did not follow up with the SF regarding missed medical appointments.

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

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

Conversations with the 4yo SS were lacking key safety-related questions; the child was asked about allegations only. No full interview was complete. Additionally, not all BF’s were added or attempted to be contacted. It was reported a SS's BF was a sex offender, despite this, the SS was placed in his care without documentation of ACS addressing the claim.

Legal Reference:

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

Action:

ACS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation. 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.

Issue:

Adequacy of Progress Notes

Summary:

The then 1yo SS had an appointment to be assessed medically for a burn. Medical professionals recommended the SS have a full skeletal exam. The SF missed three appointments. Although ACS followed up with the BF, the 1yo SS received medical care, and ACS received medical documentation, ACS' actions and efforts were not reflected in the case record.

Legal Reference:

18 NYCRR 428.5

Action:

In addition to conditions enumerated in a report, ACS is required to determine any other condition that may constitute abuse or maltreatment. ACS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/04/2024	Sibling, Male, 9 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated	Yes
	Sibling, Male, 9 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 7 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Male, 7 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Male, 4 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 3 Years	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 3 Years	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 1 Months	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 1 Months	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 1 Months	Mother, Female, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated	

Deceased Child, Male, 1 Months	Mother, Female, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 9 Years	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 9 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 7 Years	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 7 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 4 Years	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Male, 4 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 3 Years	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 3 Years	Father, Male, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Female, 1 Months	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated
Sibling, Female, 1 Months	Father, Male, 31 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 1 Months	Father, Male, 31 Years	Inadequate Food / Clothing / Shelter	Substantiated
Deceased Child, Male, 1 Months	Father, Male, 31 Years	Inadequate Guardianship	Substantiated
Sibling, Male, 9 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Male, 7 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Male, 4 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 3 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 1 Months	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Deceased Child, Male, 1 Months	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Substantiated
Sibling, Female, 1 Months	Mother, Female, 31 Years	Lack of Medical Care	Substantiated
Sibling, Female, 1 Months	Mother, Female, 31 Years	Malnutrition / Failure to Thrive	Substantiated

Sibling, Female, 3 Years	Grandparent, Female, 54 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 3 Years	Grandparent, Female, 54 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 1 Months	Grandparent, Female, 54 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Male, 1 Months	Grandparent, Female, 54 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
Five SCR reports were received, the initial report on 4/4/24, alleged the SM was violent with the then 3yo SS's BF while holding the SS, causing the SS to hit her head. The SM would become angry, and there were concerns for the safety of all her children. The SS received scratches and pinch marks from the SM. The family resided in deplorable and unsanitary living conditions. There was marijuana, crack, and cigarettes on the SS's bed and were accessible to the children. The SM would smoke marijuana to the point of impairment and become aggressive. Additionally, the then 1-month-old was diagnosed with failure to thrive, missed several medical appointments, and required inpatient treatment.

Report Determination: Indicated | **Date of Determination:** 06/03/2024

Basis for Determination:
ACS substantiated the allegations of IG and IF/C/S against the SM and SF and the allegations of PD/AM against the SM regarding all the children, and the allegations of LMC and M/FTTH against the SM regarding the then 1-month-old SS. The allegations of IF/C/S and IG were unsubstantiated against the MGM. The home was observed to be in deplorable condition. The then 1-month-old SS was diagnosed with failure to thrive. She was malnourished and underweight. The SS missed several medical appointments and providers attempted to reach the SM to no avail until 5/17/24. On 4/18/24, while at the medical facility, the SM was admitted into an in-patient psychiatric facility for 2 weeks.

OCFS Review Results:
ACS began their investigation immediately, contacted the sources, and completed a CPS history review. ACS completed a thorough and detailed investigation; consistently monitoring the safety of the children and assessing the home, contacting collaterals, safety planning, and providing community resources, services, and beds. ACS completed all Safety and Risk Assessments accurately, filed an Article 10 neglect petition against the SM on behalf of the children and opened a preventive services case. ACS did not attempt to contact all the children's BFs.

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:
Even after the children were no longer able to be cared for by the SM, ACS did not attempt to identify one BF, and did not attempt to locate, add or engage another BF.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
ACS will make casework contacts per 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:
Pre-Determination/Assessment of Current Safety/Risk

Summary:

It was reported to ACS that the then 3yo SS's BF was a sex offender. ACS did not investigate these claims or give explanation as to how it was determined the SS was safe in his care.

Legal Reference:

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

Action:

ACS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an on-going assessment of safety and risk throughout the length of the investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/19/2023	Sibling, Male, 9 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Male, 7 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 9 Years	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 7 Years	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 30 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Report Summary:

The SM and SF were aware the home was in deplorable conditions and posed a health and safety hazard to all the SSs. There was garbage and debris throughout the home, clothing all over, dirty dishes and no furniture. It was unknown if the children had been injured or become ill as a result. Additional information was received that stated on 10/27/23, the children's doctor observed the children to be unkempt and not clean, and the SM's mental health was a concern as she appeared to be disoriented when asking questions.

Report Determination: Unfounded | **Date of Determination:** 12/18/2023

Basis for Determination:

ACS unsubstantiated the allegations of IF/C/S against the SM and SF regarding the then 9, 7, and 3yo SSs due to finding no preponderance of evidence. ACS observed that the home was clean, uncluttered, had adequate food, and each child had their own sleeping arrangement.

OCFS Review Results:

ACS began their investigation immediately, contacted the source and completed a CPS history check. ACS visited the family, interviewed everyone, and assessed the home throughout the investigation. ACS contacted school staff, neighbors, the PGM, and observed records of the children's physicals. ACS provided the family with community resources and safe sleep documents, made a referral for a daycare voucher, a referral for the SM to be in a prenatal program, and contacted housing to have home repairs completed. ACS completed the Safety and Risk Assessments accurately and closed the investigation timely. ACS did not contact all BFs, and there was a gap in casework from 10/25/23-11/30/23.

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 did not identify, add, notify, or attempt to contact all the BFs.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

ACS will make casework contacts per 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)	Status/Outcome	Compliance Issue(s)
06/06/2023	Sibling, Male, 8 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 2 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 5 Months	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 8 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 3 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 2 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Deceased Child, Male, 5 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 8 Years	Mother, Female, 30 Years	Educational Neglect	Far-Closed	
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Educational Neglect	Far-Closed	

Report Summary:

On 6/6/23, the SM was highly impaired while the sole caretaker for all the SSs. The SM was speaking gibberish and was incoherent. Both the 8 and 6yo SSs had missed approximately 70 days of school thus far that school year and were consequently below grade level. The 8yo SS was classified with a speech and language impairment and was not consistently receiving services provided by the school, including speech therapy. The SM was aware; however, failed to

adequately address the situation to ensure their attendance and academic progress. Additional information was received stating that the SM and SF were involved in a verbal altercation while the children were present.

OCFS Review Results:
ACS initiated their case immediately, completed a CPS history check, and contacted the source. ACS made significant home visits and contact with the family and provided resources for DV, food pantries, and crisis intervention. When ACS learned of new information, the FAR approach was re-evaluated, and it was decided to remain a FAR case. Although ACS mentioned discussions with the family, there was no clear documentation of interviews or conversations with the individual children and parents. ACS did not identify or engage all the BFs. The Safety Assessments and FLAG were completed timely and accurately.

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

Issue:

FAR-Failure to Engage the Family

Summary:

The SF was spoken with briefly; however, there were no attempts to identify or engage the SS's BFs and there was no documentation of specific conversations with the children pertaining to safety and risk.

Legal Reference:

18 NYCRR 432.13 (e)(2)(iii)

Action:

To the extent feasible, child protective service workers should include all family members in discussions, including children who are old enough to express opinions, as well as any other persons who the family would like to include, such as members of the extended family.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/16/2023	Sibling, Male, 8 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 3 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 2 Years	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 2 Months	Mother, Female, 30 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 3 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Female, 2 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Deceased Child, Male, 2 Months	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 8 Years	Mother, Female, 30 Years	Educational Neglect	Far-Closed	

Sibling, Male, 6 Years	Mother, Female, 30 Years	Educational Neglect	Far-Closed

Report Summary:
On 3/15/23, the mother was high and impaired while caring for the then 2yo SS and the SC. The home smelled of garbage. There was water on the floor. The mother and children had very poor hygiene. The then 8 and 6yo SSs had missed 45 days of school and were failing. The mother was aware and failed to ensure the children were attending school regularly.

OCFS Review Results:
ACS engaged with the family immediately, assessed the home throughout the case, completed a CPS history review, contacted all relevant collaterals, and coordinated services and resources in regard to home repairs, home cleaning, providing the family with clothing, food, and beds, assisting with a daycare voucher, enrolling the children in summer camp, and completing referrals. ACS documented engaging the family in completing the FLAG; however, did not document specific conversation and engagement with any of the children. ACS spoke with the SF; however, did not identify, add or attempt to engage the SS's BFs.

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

Issue:

FAR-Failure to Engage the Family

Summary:

ACS did not attempt to identify all the BFs. The SF was spoken with briefly; however, there were no attempt to identify or engage the SS's BFs. There was no documentation of conversation with the children.

Legal Reference:

18 NYCRR 432.13 (e)(2)(iii)

Action:

To the extent feasible, child protective service workers should include all family members in discussions, including children who are old enough to express opinions, as well as any other persons who the family would like to include, such as members of the extended family.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/23/2022	Sibling, Male, 7 Years	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Far-Closed	Yes
	Sibling, Male, 5 Months	Mother, Female, 29 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 7 Years	Mother, Female, 29 Years	Educational Neglect	Far-Closed	
	Sibling, Male, 5 Months	Mother, Female, 29 Years	Educational Neglect	Far-Closed	

Report Summary:
The then 7 and 5yo SSs had been absent 57 days and tardy 38 days during the 2021-2022 school year and were failing as a result. The mother was aware and failed to adequately address the situation. The children were dirty and disheveled. Their clothes were dirty, and they had a foul body odor.

OCFS Review Results:
ACS made numerous visits to the home to assess the condition and the family, and to address the ongoing concerns of the home condition and schooling. ACS made diligent efforts to provide the family with an in-home cleaning service, an

exterminator, and resources; however, the SM refused to cooperate. ACS explained FAR, provided the family with beds, spoke with collaterals, and confirmed the family's whereabouts when they left NY. Although the SM was uncooperative, she confirmed they would be returning to NY, and despite the concerns, ACS closed the case prior to their return. ACS made no attempts to engage BFs and did not complete the final safety assessment accurately.

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

Issue:

FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible

Summary:

No BFs were added to the case. ACS did not attempt to identify or notify all the BFs. One BF was identified and although ACS visited the children in his care, there was no attempt to engage or interview him, or explain the allegations.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)

Action:

To the extent feasible, child protective service workers should include all family members in discussions, including children who are old enough to express opinions, as well as any other persons who the family would like to include, such as members of the extended family.

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

An investigation was opened from 5/1/18-6/25/28, with allegations of IG and L/W/B unsubstantiated against the SM regarding a SS.

An investigation was opened from 6/28/18-8/16/18, with allegations of IG substantiated against the SSs BF regarding two SSs.

An investigation was opened from 10/3/18-11/30/18, with allegations of IG unsubstantiated against the SM regarding two SSs and allegations of IG substantiated against the SSs BF regarding two SSs.

An investigation was opened from 12/29/18-2/13/19, with allegations of IG were unsubstantiated against the SM regarding two SSs.

An investigation was opened from 3/30/21-5/5/21, with allegations of IG unsubstantiated against the SM regarding a SS and OC.

An investigation was opened from 9/24/21-11/22/21, with allegations of LMC unsubstantiated against the SM regarding a SS.

An investigation was opened from 8/3/20-9/15/20, with allegations of IG unsubstantiated against the SM regarding a SS and OC, and allegations of IG unsubstantiated against a BF regarding a SS and allegations of IG and S/D/S regarding OC.

An investigation was opened from 9/16/20-10/19/20, with allegations of IG unsubstantiated against the SM regarding 4 SSs.

An investigation was opened from 11/27/20-1/24/21, with allegations of XCP unsubstantiated against the SM regarding OC.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 07/03/2024

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 07/03/2024

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

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

Services Provided

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

Family Assessment and Service Plan (FASP)

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

Closing

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

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
Records indicated that the 4yo SS's BF was charged with rape 3 and sex abuse-3rd: subject another person to sex contact without consent. He was sentences to 6 years of probation. There was no documentation that ACS followed up with these concerns and no explanation as to how it was determined the SS was safe in his care.

Preventive Services History

A preventive services case was opened from 4/18/24-7/3/24 due to concerns for the SM's mental health, the condition of the home, and educational neglect. A neglect petition was filed on 5/20/24. An OP was issued against the SM in favor of the children, and the SM was only allowed to be supervised with the children. Another OP was issued against the SM regarding the MGM. The 3 oldest children were in the care of the MGM, the 2 youngest children were in the care of the SF, and the other child was in the care of her BF. The same day the preventive case was closed, another was opened.

A preventive service case was opened from 6/29/18-2/1/22 due to concerns for DV. The 4 oldest SSs were placed in foster care after the BF of the two oldest SSs physically assaulted the SM to the point of impairment. As a result, the SM was in a coma and was unable to care for the SSs. When the SM was recovered and able to care for the SSs, they were placed back into her care on 7/26/18. The BF was arrested, incarcerated and released in March 2020. The court order of supervision ended on 1/13/22.

Foster Care Placement History

A preventive services case was opened from 6/29/18-2/1/22 due to concerns for DV. The 4 oldest SSs were placed in

foster care after the BF of the two oldest SSs physically assaulted the SM to the point of impairment. As a result, the SM was in a coma and was unable to care for the SSs. When the SM recovered and was able to care for the SSs, they were placed back into her care on 7/26/18. The BF was arrested, incarcerated and released in March 2020. The court order of supervision ended on 1/13/22.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒Family Court ☒Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/20/2024	There was not a fact finding	Order of Supervision
Respondent:	Mother Female 32 Year(s)	
Comments:	An FSS was opened from 4/18/24-7/3/24 due concerns for the SM's mental health, the condition of the home, and educational neglect. A neglect petition was filed on the SM and SF on 5/20/24. An OOP was issued against the SM in favor of the children and the SM was only allowed to be supervised with the children. Another OOP was issued against the SM regarding the MGM. The three oldest children were in the care of the MGM, the 2 youngest children were in the care of the SF and the SF was under ACS supervision, and the other child was in the care of her BF.	

Criminal Charge: Other - Loaded Fire Arm **Degree:** NA

Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
08/27/2023	BF of the 2 oldest SSs	04/12/2024	Unknown
Comments:	The 2 oldest SS's BF was arrested in August 2023 for having a loaded firearm. He was sentenced to 3 years and 6 months in prison. Prior to this in 2019, he was charged with assault with a weapon in the 2nd, pled guilty and went to prison.		

Have any Orders of Protection been issued? Yes

From: 05/20/2024	**To:** Unknown

Explain:
An Article 10 neglect petition was filed on 5/20/24. An OP was issued against the SM in favor of the children and the MGM, and the SM was only allowed to be supervised with the children. In 2018, an OP was issued against the 2 oldest SS's BF due to him violently assaulting the SM, putting her into a coma.

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