Child Fatality Report

Report Identification Number: NY-25-049

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

Issue Date: Sep 30, 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

Jurisdiction: Office Of Special Investigations

Date of Death: 05/11/2025

Age: 1 month(s)

Gender: Male

Initial Date OCFS Notified: 05/12/2025

Presenting Information

An SCR report was received that alleged, while in the care of the foster mother, the 2-month-old subject child passed away. On 05/11/25, at 7:00AM, the foster mother fed and burped the subject child and he went back to sleep. At 10:00AM, the foster mother went to check on the subject child and he was cold to the touch and not breathing. The foster mother called 911 and the subject child was transported to the hospital where he was pronounced deceased. The foster mother was unable to provide an explanation for the subject child's death. Additional information was received, the source reported the foster mother had two foster children in her care and that she consumed alcohol in their presence and would treat the children inappropriately.

Executive Summary

The New York City Administration for Children's Services (ACS) received an SCR report on 5/12/25, that alleged on 5/11/25, the 1-month-old male subject child passed away. The subject child was placed in foster care and at the time of his death was asleep with the foster mother on her bed. The foster mother woke and found the subject child unresponsive. The report contains allegations of Inadequate Guardianship and DOA/Fatality. There were no surviving siblings; however, the foster mother's child, and two other foster children (FC1 and FC2) were residing with the subject child and foster mother. The subject child's mother was residing at her own foster care placement.

ACS learned that the foster mother fed the subject child around 7:00AM, and then put him back to sleep on her bed with her. When she woke around 11:40AM, she found the subject child unresponsive. She contacted 911 and the subject child was transported to the hospital where he was pronounced deceased.

The medical examiner performed an autopsy and the results were pending. It was determined the subject child had no injuries. Law enforcement investigated the death by speaking with the family, the hospital and the medical examiner, and closed their case without charges due to no concerns of trauma, abuse or foul play.

ACS did not document attempts to contact the mother; therefore, did not offer bereavement resources. There was no documentation of ACS providing the foster mother or children in her home with bereavement resources. There was no need for funeral assistance to be provided to the family as the subject child was in the custody of the ACS commissioner. ACS did not complete the 24-hour Fatality Report timely and did not complete the 7 Day Safety Assessments nor the 30 Day Safety Assessments.

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:
The case was indicated and closed appropriately.

Was the decision to close the case appropriate? Yes

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 was not commensurate with case circumstances as several parents were not notified, the 24-hour Fatality Report was not completed timely and lacked details, neither the 7 Day Safety Assessment, nor the 30 Day Safety Assessments were completed, and one of the children had several person ID's and names in CONNECTIONS there were not merged.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	A 24-hour Fatality Report was not completed and approved in CONNECTIONS within 24 hours of receipt of the report. It was completed on 6/4/25. The report did not include all available information regarding the circumstances of the SC's death.
Legal Reference:	CPS Program Manual, Chapter 6, K-1

Action:	ACS must document and approve a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in CONNX for all reports containing an allegation of a child fatality.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-Day Safety Assessment was not completed.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS will document and approve all Safety Assessments within the required timeframes.
Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	The foster mother's child had two person IDs under one name and another person ID under another name. None of the person IDs were merged.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The 7-Day Safety Assessment was not completed.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS will document and approve all Safety Assessments within the required timeframes.
Issue:	Failure to provide notice of report
Summary:	ACS did not provide attempt to notify, contact and or interview the SC’s BM, or the foster children’s parents.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
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.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/11/2025 **Time of Death:** Unknown

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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
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	1 Month(s)
Deceased Child's Household	Foster Parent	Alleged Perpetrator	Female	61 Year(s)
Deceased Child's Household	Other Child - Foster Child 1	No Role	Male	17 Year(s)
Deceased Child's Household	Other Child - Foster Child 2	No Role	Male	11 Year(s)
Deceased Child's Household	Other Child - Foster Mother's Child	No Role	Female	5 Year(s)
Other Household 1	Mother	No Role	Female	19 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS initiated their investigation within 24 hours, completed a CPS history check, coordinated their efforts with LE, spoke with the ME and notified the DA of the fatality. ACS determined that the foster mother's child, FC1 and FC2 were safe in the care of the FM.

The FM observed the SC to have the “shakes” on 5/1/25. She brought the SC to the hospital, and he was transferred to another hospital that was more equipped to deal with the circumstances. The SC underwent testing that indicated he may have had "something in his head." The SC was discharged on 5/9/25 with plans to follow up with the neurologist. The FM explained she was uncomfortable with the SC being discharged due to him still having the “shakes”.

The FM explained, the night prior to the fatality, the SC was eating regularly and had normal bowel movements. He went to sleep around 10:00PM, woke for a feeding around 4:00AM, and slept until about 7:00AM the next morning. The FM gave the SC a bottle and then held him on a nursing pillow and fell asleep. She reported falling asleep before 8:00AM, and waking around 11:00AM to find the SC’s arm bent with his hand on his forehead area. She went to move his arm and felt he was stiff and cold. The FM contacted 911. On another occasion, the FM gave a different timeline of the events that indicated she waited about an hour after finding the SC, to contact 911. The FM went with the SC to the hospital, where he

was pronounced deceased between 3:00PM and 4:00PM. ACS was able to observe the bed and nursing pillow.

FC2 reported being in bed the morning of the incident and waking to the FM being distraught because the SC was not moving. FC2 observed the FM contact 911 and EMS told the FM to perform CPR. FC2 stated the SC had some milk come out of his nose and was breathing "a bit then stopped." FC2 reported observing the SC's legs shaking 2 days prior to the fatal incident, on 5/9/25, the day the SC was discharged from the hospital. The foster mother's child reported she was asleep when the fatal incident occurred and did not see what happened. Both children reported the SC would sleep in the Pack 'N Play next to the FM's bed. FC1 did not add any information pertaining to the fatal incident.

The case planner with the foster care agency, reported that the FM told her that she fed the SC, burped him, and had him cradled in her arms when they fell asleep. When she woke, she found the SC unresponsive, cold and stiff. The case planner also confirmed the details surrounding the SC's hospital stay from 5/1/25-5/9/25 and added that the SC was diagnosed with benign lesions on his brain. The foster care agency visited the SC at the FM's home on 5/9/25, and he appeared to be well.

ACS planned with the foster care agency, that they would implement safe sleep training courses and that the agency would not place a child under the age of 1 year in the FM's care.

ACS contacted appropriate collaterals, except for EMS, and gathered school and medical records regarding the surviving children and the SC's neurology and hospital records from his 5/1/25 hospital stay. The hospital refused to provide ACS with records pertaining to the SC's death despite the SC being in ACS' custody. ACS completed case notes and the investigation timely and appropriately determined the allegations, substantiating the FM for IG and unsubstantiating her for DOA/Fatality.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
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
071869 - Deceased Child, Male, 1 Month(s)	071870 - Foster Parent, Female, 61 Year(s)	DOA / Fatality	Unsubstantiated
071869 - Deceased Child, Male, 1 Month(s)	071870 - Foster Parent, Female, 61 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	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
Caretakers / Babysitters	☐	☐	☐	☒
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:
Two of the surviving children in the household were foster children; however, the Risk Assessment documented that none of the children were ever placed outside of their homes. It was identified that bereavement resources were to be offered to the family; however, there was no documentation in the case record that they were provided.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

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

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

Additional information, if necessary:
Two of the surviving children in the household were foster children. The foster children were receiving foster care services. The family was not offered bereavement resources. The SC was in foster care and in the custody of the county; therefore, funeral assistance did not need to be offered.

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:
There were two foster children and the foster mother's child in the home at the time of the SC's death. There is no documentation in the case record that bereavement resources were provided. FC2 was engaged in mental health treatment.

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:
There is no documentation in the case record that bereavement resources were provided to the foster mother or biological 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
- ☐ 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)
03/26/2025	Deceased Child, Male, 11 Days	Mother, Female, 19 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 11 Days	Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report was received on 3/26/25, that alleged the BM had MH issues and was unstable. She was not compliant with services and had no plan for the 11-day-old SC. There was concern the BM was going to “take off” with the SC. It was unknown if the mother had appropriate provisions for the SC. A subsequent report was received on 4/9/25, that alleged the BM had a history of marijuana use and on 4/7/25, the BM was using marijuana to the point of impairment in the presence of the 2-week-old SC. While impaired, the BM experienced mood swings and was incoherent, erratic, agitated and aggressive. The BM abruptly left the residence with the SC, despite the late hour and cold weather.

Report Determination: Indicated	**Date of Determination:** 05/21/2025

Basis for Determination:
The allegations of IG and PD/AM were substantiated against the BM regarding the SC. The BM was smoking marijuana at the hospital in the bathroom of the NICU. The BM was discharged from a mother/child program due to her appearing to meet a drug dealer at the residence. The BM left the SC at the program on 4/7/25, and staff and other members had to care for the SC. The BM did not appear to be able to adequately care for the SC.

OCFS Review Results:
ACS began their investigation within 24 hours, contacted the source and completed a CPS history review. ACS spoke with medical staff, foster care agencies, residence staff and case planners. ACS attempted to get LE records pertaining to the BM being incarcerated. ACS assessed the SC to not be safe with the BM, filed an Article 10 neglect petition, made diligent efforts to assist the BM with the judge's order for the BM and SC to remain together, completed an emergency removal, and filed an Order to Show Cause. Safey and Risk Assessments were completed accurately. Eighteen out of 48 progress notes were completed untimely. The case was determined appropriately and closed timely.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/14/2022	Other Child - Foster Child 2, Male, 8 Years	Foster Parent, Female, 58 Years	Inadequate Guardianship	Unsubstantiated	No
	Other Child - Foster Mother's Child, Female, 2 Years	Foster Parent, Female, 58 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Foster Child not involved in DOA/Fatality, Male, 13 Years	Foster Parent, Female, 58 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Foster Child 2, Male, 8 Years	Foster Parent, Female, 58 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Other Child - Foster Child not involved in DOA/Fatality, Male, 13 Years	Other Adult - Foster Mother's Cousin, Female, 49 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Foster Child not involved in DOA/Fatality, Male, 13 Years	Other Adult - Foster Mother's Cousin, Female, 49 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
An SCR report was received that alleged on 4/13/22, the FM and 13yo OC engaged in a verbal altercation. The FM had a kitchen knife and was using it in a threatening manner. An unrelated home member grabbed the OC by the arm during the altercation, causing him to fall to the ground and sustain a laceration on his arm. The OC no longer felt safe in the home. The foster mother's child and FC2 were present and not physically harmed. A subsequent report was received that alleged on 4/24/22, FC2 presented with bruises on the buttocks and back. The injuries occurred while in the care of the FM. FC2 did not have any underwear or socks and had dirty clothes.

Report Determination: Unfounded	**Date of Determination:** 06/14/2022

Basis for Determination:
The allegations of IG and L/B/W regarding FC2 and the allegations of IG regarding the AC and OC against the FM were unsubstantiated. The allegations of IG and L/B/W regarding OC were unsubstantiated against another adult. Upon investigation, the OC sustained minor scratches to his left arm, and they were not substantial enough to receive medical attention. All parties stated that the FM was not holding the knife in a threatening manner and was not using it with the intention of harming anyone. In the Investigation Conclusion Narrative, ACS did not address the concerns pertaining to FC2.

OCFS Review Results:
ACS began their investigation within 24 hours, contacted the sources, and completed a CPS history review of the FM. ACS assessed the home and the children. ACS interviewed the FM, other adult in the home and the children. The OC was placed in three other foster home's during the investigation. FC2 and the foster mother's child were determined to be safe in the care of the FM. Safety and Risk Assessments were completed accurately, case notes were entered timely, and the case was closed timely. ACS did not contact medical collaterals for any of the children and only spoke with one school. ACS did not document notifying the biological parents of the SCR report.

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

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

An investigation was opened from 7/20/20-9/18/20, with allegations of IG, IF/C/S and LS against the FM being unsubstantiated regarding other children.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 03/28/2025

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?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

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?	☐	☒	☐	☐
If not, how many days was it overdue? 12 Days				
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?	☐	☐	☒	☐

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	A Plan Amendment was not completed following the fatal incident. The incident could have been documented in the June 2025 FASP; however, at the time of this writing, it was a month overdue.
Legal Reference:	18 NYCRR428.3(f)

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.

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: 04/07/2025
Date of placement with most recent caregiver? 04/09/2025
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:** 11/10/2023	☒	☐	☐	☐
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 SC was placed in foster care on 4/7/25 and passed away on 5/11/25. Due to foster care services only being in place for 5 weeks, there was not ample time for services to be provided. During the 5 weeks the SC was in care, there were no concerns for the foster care agency to provide services.

Foster Care Placement History

A preventive service case opened on 3/28/25, regarding the SC's foster care placement. An Article 10 neglect petition was filed on 4/1/25. An emergency removal was done on 4/7/25 and ACS filed an order to show cause. It appeared an outside foster care agency was providing foster care services to the family.

A preventive services case opened on 6/11/21, regarding the BM being placed in foster care.

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:**
04/01/2025	There was not a fact finding	Order of Supervision
Respondent:	Mother Female 19 Year(s)	
Comments:	ACS filed an Article 10 neglect petition on 4/1/25 against the BM regarding the SC. The BM was ordered to enter a mother and child program where she and the SC would reside.	

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
04/08/2025	There was not a fact finding	Care/Custody to OCFS Commissioner

Respondent:	None
Comments:	On 4/7/25, ACS did an emergency removal of the SC from the BM. As a result, the filed an Order to Show Cause and the child was remanded.

Criminal Charge: Other - Larceny and Breaking a Court Order **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Unknown	Mother	Unknown	Unknown
Comments:	In January 2025, the BM was incarcerated while pregnant for Larceny and for breaking a court order to comply with her mental health treatment.		

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