Child Fatality Report

Report Identification Number: NY-25-058

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
Age: 2 month(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 06/08/2025
Initial Date OCFS Notified: 06/08/2025

Presenting Information

An SCR report was received on 6/8/25 which alleged at 8:37AM, the mother woke up and found the subject child unresponsive. The mother called 911 but was unable to provide the family's location so the parents drove to the hospital. Life-saving measures were performed but were unsuccessful and the child was pronounced deceased at 8:55AM. The child was an otherwise healthy child, and the parents did not have an explanation for her death. The child was under weight, filthy and the siblings were filthy and had an offensive odor. A second report was received with substantively similar information, adding the family was traveling from out-of-state, the child only weighed 6lbs at death, and the parents did not have food to provide the siblings, so they were hungry. A third report was received adding that on 6/8/25, at 3:00AM, the mother placed the child in a car seat and slept outside on a front lawn. She fed the child at 6:00AM and found her unresponsive around 8:00AM.

Executive Summary

This report concerns the death of the 2-month-old female subject child. The Administration for Children's Services (ACS) received three SCR reports regarding the child's death, as well as concerns regarding the siblings. At the time of the child's death, she was in the custody of her parents and resided with her siblings, ages 9, 7, 5, 4, 4, 2, and 1. The family appeared to be transient, and NYS was not their state of residence.

The family of 10 arrived in NYS via two separate vehicles on 6/7/25 to attend a birthday party at a family friend's residence. The party was for "the mother's people" and the father waited in his vehicle with one of the 4-year-old siblings for the duration of the party, having pizza delivered to the vehicle at 11:37PM and falling asleep with the sibling around 12:50AM. After the party, the mother's vehicle would not start and the hotel the family planned to stay at no longer had rooms available, so they decided to sleep in the vehicles. It was unknown if either vehicle's windows were down or if climate control was used to moderate the temperature. The mother reported feeding the subject child at 2:00AM and 6:00AM. Following the 6:00AM feeding, the child was burped, her diaper was changed, and she was put back to sleep in her car seat. When the mother went to feed the child at 8:00AM, she noticed something was wrong. The mother woke the father, and the father called 911, but the family was unable to provide locating information as they were unfamiliar with the area, so the father drove the entire family in his vehicle to the hospital. Upon arrival, the mother went inside with the child and the father waited in the vehicle with the siblings. The child was cold on arrival and life-saving measures were attempted, but unsuccessful. The child was pronounced deceased at 8:55AM.

The medical examiner was notified and performed an autopsy on the child. The autopsy report was expected to take three to six months, as there was outstanding testing not yet received; therefore, the final cause and manner of death remained pending. The medical examiner reported the child was very thin, and in the 0 percentile for weight, inferring the child was not being fed. The medical examiner reported malnourishment may be a contributory cause and expressed concern the manner of death may be homicide. The hospital physician working on the child described her as "emaciated." The child had sunken fontanelles, looked dehydrated, and was unkempt. The siblings were described by hospital staff and law enforcement as "completely disheveled." They had dirty clothes, were unkempt, looked skinny for their given ages, and had a foul smell. Law enforcement's investigation into the death was ongoing, though the parents were arrested for unrelated outstanding charges during the CPS investigation.

Due to concerns regarding their safety and well-being, the siblings were assessed at the hospital and removed from the parents care on 6/8/25.

The allegations of Inadequate Food/Clothing/Shelter, and Inadequate Guardianship were appropriately substantiated for all the children. The allegation of DOA/Fatality was inappropriately unsubstantiated regarding the subject child. ACS concluded there was no information to suggest either parent "intentionally caused" the death of the child. While conscious intent may not have been present, the evidence available at the time the CPS investigation was determined indicated the parents' actions/inactions contributed to the death, in that the child was malnourished to the point of having lost one pound of her birth weight at only 2 months old (from 7lb 6oz to 6lbs) and was in the 0 percentile for weight: alarming enough to consider homicide as the manner of death.

A family services stage (FSS) was opened due to the siblings' foster care placement and ongoing service needs of the family.

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 Risk Assessment Profile was completed inaccurately and DOA/Fatality was inappropriately determined. Intent should not be the sole deciding factor as to whether the allegation is substantiated or not.

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:
In addition to the concerns enumerated in the report (IF/C/S and IG), the additional allegation of Educational Neglect could have been considered for the school-aged siblings, as it did not appear they were enrolled in educational programming. Additionally, Lack of Medical Care could have been explored by obtaining pediatric medical records timely. However, the indication overall was appropriate.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ACS justified unsubstantiating the allegation of DOA/Fatality by stating there was no intent to cause the death. Intent aside, there was information in the record to support the allegation based on the ME's assessment and evidence gathered.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the NYC Regional Office if further guidance is needed.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	Elevated Risk Elements were scored incorrectly. The SSs were not removed prior to the current report. The decision to mark "yes" to death of child due to abuse/maltreatment by caretaker was correct, but inconsistent with ACS's determination to Unsub.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.
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 documented and approved in CONNECTIONS timely. The report was due 6/9/25 and not approved until 8/5/25.
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 CONNECTIONS for all reports containing an allegation of a child fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/08/2025 **Time of Death:** 08:55 AM

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

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	33 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	7 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	4 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Year(s)

LDSS Response

On 6/8/25, ACS received multiple SCR reports regarding the death of the subject child, as well as concerns regarding the siblings. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the sources of the reports, notified the DA, and completed a CPS history check regarding the family, which

revealed no NYS child welfare history; however, ACS diligently checked out-of-state history based on the family's reported addresses, which did yield a history of child welfare concerns. The safety of the siblings was assessed, and the siblings were removed on 6/8/25.

ACS interviewed the parents regarding the events leading up to their arrival in NYS on 6/7/25, and the child's subsequent death. The family traveled to attend a birthday party for a family friend. Their journey originated out of state, and the father stated the family (of ten) began the drive in his vehicle, with the subject child in a car seat and the siblings buckled in seatbelts. While the father stated his vehicle had enough seatbelts, the reported seating capacity of his vehicle was five passengers, which the family far exceeded. Additionally, due to the children's ages, the family required a minimum of six car seats. The family reportedly had only one or two car seats. Along the way, the family picked up a second vehicle and continued driving to NYS; the mother with five children, the father with the remaining three. After the party, the mother's vehicle would not start and the family was unable to secure a hotel room, so they slept in the two vehicles overnight. The mother reported feeding the subject child at 2:00AM, 6:00AM, and when she went to feed the child at 8:00AM, she noticed something was not right. Unable to provide a location to 911, the family drove in the father's vehicle to the hospital. The mother reported the child was born at 7lbs, 6oz and was fed 4-6oz every two hours, yet at death, the child only weighed 6lbs. The parents reported the child received immunizations at her two-month well-child visit (5/12/25). The child had reported cold-like symptoms following the immunizations in May, and the father felt the immunizations caused the death.

The siblings were interviewed. There were inconsistent reports of where the family resided, and whether they resided in a home or a vehicle. It did not appear the school-age siblings had attended school.

ACS spoke with the ME, who reported it was likely the child was not being fed. There was outstanding toxicology, pathology and genetic testing results needed prior to finalizing the autopsy report. The ME reported malnourishment may be a contributory factor and was concerned about the possibility of homicide.

ACS learned the parents were arrested on 6/30/25 in another state due to outstanding warrants unrelated to the death. Both parents were incarcerated and extradited. Law enforcement's investigation into the death remained pending the autopsy report. Attempts to gather pediatric records were not made until the end of the investigation. The subject child's pediatrician would only confirm the child was a patient, and the siblings' alleged pediatric office had not yet responded to outreach.

At the close of the CPS investigation, the siblings remained in foster care. The father was paroled out-of-state, and the mother remained incarcerated outside NYS. ACS indicated the report and closed the investigation. Ongoing casework activity continued in the FSS.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Pending

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

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

Comments: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
071988 - Deceased Child, Female, 2 Month(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071988 - Deceased Child, Female, 2 Month(s)	071990 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
071988 - Deceased Child, Female, 2 Month(s)	071989 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
071988 - Deceased Child, Female, 2 Month(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071988 - Deceased Child, Female, 2 Month(s)	071990 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071988 - Deceased Child, Female, 2 Month(s)	071990 - Father, Male, 33 Year(s)	DOA / Fatality	Unsubstantiated
071991 - Sibling, Male, 9 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071991 - Sibling, Male, 9 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
071991 - Sibling, Male, 9 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071991 - Sibling, Male, 9 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071992 - Sibling, Female, 7 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071992 - Sibling, Female, 7 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071992 - Sibling, Female, 7 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
071992 - Sibling, Female, 7 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071993 - Sibling, Female, 5 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071993 - Sibling, Female, 5 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071993 - Sibling, Female, 5 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
071993 - Sibling, Female, 5 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071994 - Sibling, Male, 4 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated

071994 - Sibling, Male, 4 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
071994 - Sibling, Male, 4 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071994 - Sibling, Male, 4 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071995 - Sibling, Male, 4 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
071995 - Sibling, Male, 4 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071995 - Sibling, Male, 4 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071995 - Sibling, Male, 4 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071996 - Sibling, Female, 2 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071996 - Sibling, Female, 2 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071996 - Sibling, Female, 2 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071996 - Sibling, Female, 2 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
071997 - Sibling, Female, 1 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071997 - Sibling, Female, 1 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
071997 - Sibling, Female, 1 Year(s)	071990 - Father, Male, 33 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
071997 - Sibling, Female, 1 Year(s)	071989 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

CPS Fatality Casework/Investigative Activities

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

All appropriate Collaterals contacted?	☒	☐	☐	☐
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:
The RAP was not scored consistent with the record and determination; however, the risk score was accurate given DOA/Fatality should have been substantiated.

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
The family provided inconsistent information regarding their state of residence and it was believed at the time of removal, the family was residing in their car. The siblings were assessed at the hospital following the fatality and were observed to be unkempt, malnourished, and with foul body odor. The siblings were removed at the hospital.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
06/09/2025	There was not a fact finding	Article 10 Remand
Respondent:	Father Male 33 Year(s), Mother Female 30 Year(s)	
Comments:	The siblings were removed on an emergency basis on 6/8/25. A neglect petition was filed in family court on 6/9/25 requesting the removal of the siblings. A remand was granted for all surviving siblings and they were placed in non-kinship foster care, between two homes. Visitation was held between the siblings to maintain sibling contact. The parents were permitted supervised in-person and virtual visitation. Much of the visitation occurred virtually as the parents were out of state. Foster care services were provided by a contract agency. At the time this fatality report was written, the Interstate Compact on the Placement of Children (ICPC) had been initiated for two paternal relatives who expressed their	

	desire to be placement resources for the siblings. The parents were in support of ICPC placement. Family court proceedings were ongoing.

Have any Orders of Protection been issued? Yes	
From: 06/09/2025	**To:** Unknown
Explain: On the date the Article 10 remand was granted, a Stay Away Order of Protection was also issued against the parents on behalf of the surviving siblings. The Order did allow for agency supervised visitation between the parents and siblings.	

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:
The parents' out-of-state incarcerations following the fatality impacted the ability to offer and initiate services.

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
In response to the fatality investigation, the siblings were removed and placed in foster care. The services plan included enrolling the school-aged siblings in school, and enrolling the siblings in either grief counseling or play therapy, depending on age.

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:
As part of the FSS, the parents' services plan included referrals to individual and grief counseling. Additionally, the parents were to participate in parenting skills programs and secure stable housing. The status of counseling services was unknown as the parents were arrested shortly following the fatality and had not returned to NYS at the time this report was written.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family had prior child welfare history outside of NYS with a pattern of concerns regarding the family residing in their vehicle and hotels, as well as the CHN being unkempt.

March 2025: reported concerns of neglect. The family appeared to receive services similar to NYS FAR. OCFS requested records from the relevant state; however, the records had not been made available at the time of this review.

January 2024: reported concerns included lack of immunizations for the CHN and it was believed the family was residing in their vehicle. The family was never located and it was believed they had left that respective state.

May 2022: reported concerns were homelessness and sleeping in a vehicle, the father using marijuana and the parents not providing necessities for the CHN, and the CHN were unkempt. The family was never located.

2017: reported concerns were the mother's use of marijuana and cocaine and engaging in prostitution. The mother was referred to a drug treatment program and utilized the support of a maternal aunt. The case appeared similar to NYS FAR, and the case closed once the mother met service goals and objectives.

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

Criminal Charge: Other - Unknown **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Unknown	Mother and Father	Unknown	Unknown
Comments:	The mother and father were arrested on 6/30/25 while traveling outside NYS. Both had outstanding warrants in other jurisdictions, and were extradited to those respective jurisdictions. The father had several theft related charges. The mother had a pattern of arrest history regarding driving with a suspended license and theft. Most recently, 8/21/24, the mother was charged with vehicle-related infractions including driving without a license and not using safety restraints (car seats).		

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