Child Fatality Report

Report Identification Number: NY-25-077

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

Issue Date: Dec 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: 07/27/2025

Age: 2 year(s)

Gender: Male

Initial Date OCFS Notified: 07/28/2025

Presenting Information

An SCR report was received that alleged on 7/24/25, the 2-year-old subject child was not adequately supervised by the foster mother. The subject child went out an open screen door to the backyard and got through an open gate and fell into the pool. The subject child was found in the pool by the foster mother and the 12-year-old surviving sibling. The sibling contacted 911 and the foster mother attempted cardiopulmonary resuscitation on the subject child. Emergency Medical Services (EMS) arrived and transported the subject child to the hospital. On 7/27/25 at 9:21AM, the subject child succumbed to his injuries and was declared dead.

Executive Summary

This report concerns the death of the 2-year-old male subject child that occurred on 7/27/25. The New York City Administration for Children's Services (ACS) received an SCR report on 7/24/25, regarding the fatal incident. The initial report listed the allegation of Lack of Supervision against the foster mother regarding the subject child. The subject child remained hospitalized until his death on 7/27/25. On 7/28/25, ACS received a subsequent report with allegations of DOA/Fatality, Lack of Supervision and Inadequate Guardianship against the foster mother regarding the subject child. In addition, there was an open foster care case.

At the time of his death, the subject child resided with his foster mother and surviving siblings ages 12 and 9 years old. The biological mother resided locally and had weekly supervised visitation with the children; the biological father never met the subject child. ACS immediately initiated their investigation and removed the surviving siblings from the foster mother's home, and they were placed in another foster home where they were deemed safe.

Through a joint investigation with law enforcement, it was learned in the evening on 7/24/25, the subject child was in the care of the foster mother. The foster mother and children ate dinner around 4:45PM and shortly after, the foster mother noticed the subject child was missing. Inside the residence was searched which yielded negative results. The search continued outdoors where the foster mother found the subject in a pool submerged in 4ft of water. The foster mother immediately pulled the subject child from the water and initiated CPR while the 12-year-old surviving sibling contacted 911. Emergency responders arrived at the residence and took over life-saving efforts which were successful. The subject child was hospitalized and put on life support until his death on 7/27/25, when he succumbed to his injuries.

ACS communicated with the medical examiner's office and learned an autopsy was performed; however, the final autopsy report was pending further studies at the time of case closure. Hospital staff stated that the subject child sustained fluid in his lungs, swelling to his head and his abdomen was distended. Further testing revealed on 7/27/25, the subject child was declared brain dead.

ACS communicated with the district attorney's office and learned the investigation remained open awaiting the final autopsy report. At the time this report was written there were no criminal charges pending against the foster mother.

ACS substantiated the allegations of DOA/Fatality, Lack of Supervision and Inadequate Guardianship against the foster mother, as they found there was a fair preponderance of evidence. The investigation revealed the subject child exited the

home through a glass sliding door and screen door. The subject child proceeded to the pool which had a gate but was not locked and did not appear to be sturdy. Prior to the fatal incident, there were two other occasions where the subject child was found by the pool unsupervised. The foster mother failed to take appropriate actions to safeguard the subject child from getting out of the residence and ensuring the gate to the pool was appropriately secured. As a result of the foster mother's inaction, the subject child drowned and suffered medical conditions that contributed to his death.

ACS gathered information from collateral contacts such as law enforcement, EMS, hospital staff, the children's pediatrician, neighbors, the family, and the medical examiner's office. The record reflected bereavement services were provided to the family and foster mother. In addition, burial assistance was provided to the mother.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:

ACS made an appropriate decision to substantiate the allegations of Inadequate Guardianship, Lack of Supervision and DOA/Fatality, based on evidence obtained throughout their investigation.

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

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

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

Explain:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/27/2025 **Time of Death:** 09:21 AM

Date of fatal incident, if different than date of death: 07/24/2025
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 05:45 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

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	Foster Parent	Alleged Perpetrator	Female	60 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Other Household 1	Mother	No Role	Female	38 Year(s)

LDSS Response

On 7/24/25, ACS received a report regarding the fatal incident and on 7/28/25, received the fatality report regarding the SC's death which occurred on 7/27/25. ACS initiated their investigation within 24 hours, notified the DA, communicated with the ME, and coordinated their efforts with LE. ACS contacted the sources of the reports, completed a CPS history check, and immediately assessed the surviving siblings who were then transferred to a different foster home.

ACS interviewed the FM at her residence. During her interview, she explained dinner was served at 4:45PM. The FM, unrelated household member and the children all ate together. After dinner, the 12yo SS went to her bedroom and played on her phone, while the FM, SC and 9yo SS stayed downstairs. The FM recalled speaking to the 9yo SS in the living room and observed the SC playing with a ball. At some point, the FM noticed it was quiet and asked the 9yo SS where the SC was and to check upstairs. The 9yo SS did not find the SC upstairs and the FM opened the front door to see if the SC was outside. The FM then realized the back door was open and proceeded to walk to the pool where she found the SC face-down submerged at the bottom of the pool. The FM explained she jumped into the pool and retrieved the SC, yelled for someone to call 911, and then immediately initiated CPR. The FM recalled the SC vomited while she was doing CPR. When asked if the SC “wanders” into the backyard the FM denied stating “this was the only incident.” The FM reported the pool was 4ft deep and she could not recall how long the SC was unsupervised but estimated 10 minutes. The FM denied using the SSs to care and supervise for the SC. Information was received during the interview that the FM was aware of two other incidents involving the SC being unsupervised around the pool. The FM confirmed the two incidents were in June and July and reported the safety precaution put in place was to close and lock the door.

ACS forensically interviewed the SSs at a Child Advocacy Center. During their interviews the CHN confirmed the FM’s recollection of events. The 12yo SS added that while the 9yo SS and FM were downstairs she heard the SC go upstairs and then back downstairs. The 9yo SS confirmed they checked upstairs for the SC and then the FM found the SC in the pool. Both SSs confirmed there were two incidents prior to the fatal incident where the SC was found by the pool. The first incident the SC was found standing by the pool throwing toys into the pool and watching them sink. The second incident the SC was found halfway in the pool and was taken out by the FM. The 12yo SS reported the gate to the pool did not lock and the SC was able to open it. Both CHN confirmed the FM told them they needed to watch the SC “more.”

ACS interviewed the BM at her residence. During her interview she explained she received a phone call from the 9yo SS that the SC was found in the pool and was unresponsive. The mother spoke with EMS who informed her which hospital the SC was transported to. The mother reported she spoke to medical staff at the hospital who informed her that the SC was submerged in water and it took approximately 30 minutes to resuscitate him.

After the incident, ACS immediately removed the SSs from the FM’s residence and placed them in a new foster home. There were no other CHN in the foster home while the case was under review. The foster home was permanently closed on 8/19/25, with a recommendation to not re-open. The 9yo SS was discharged from foster care and released back to the mother under court ordered supervision. The 12yo SS was placed with a familial resource. The investigation was closed timely and the family continued to be monitored through their open services case.

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: While NYC has an OCFS approved CFRT, it is unknown if this case has been referred.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
073002 - Deceased Child, Male, 2 Year(s)	073004 - Foster Parent, Female, 60 Year(s)	DOA / Fatality	Substantiated
073002 - Deceased Child, Male, 2 Year(s)	073004 - Foster Parent, Female, 60 Year(s)	Lack of Supervision	Substantiated
073002 - Deceased Child, Male, 2 Year(s)	073004 - Foster Parent, Female, 60 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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐

Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

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

Explain as necessary:
The surviving siblings were already in foster care; however, were immediately removed from the foster mother's residence and placed in a different foster home.

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	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The siblings were referred for intensive grief counseling services and continued receiving services through their open services case.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The mother was offered bereavement and burial assistance and continued to receive services through her open services case. The foster mother was provided information regarding bereavement services.

History Prior to the Fatality

Child Information

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

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)
05/05/2025	Deceased Child, Male, 2 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 12 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 9 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report was received that alleged on 5/4/25, at 5:00PM, the biological mother had a mental health episode while in public. The mother hallucinated while acting as the sole caretaker to the subject child and surviving siblings. As a result, the children did not have an adequate caretaker at that time.

Report Determination: Indicated | **Date of Determination:** 06/27/2025

Basis for Determination:
ACS substantiated the allegation of Inadequate Guardianship against the biological mother regarding the subject child and surviving siblings. The mother was admitted to the hospital for 11 days due to mental health conditions. The children were removed and placed into foster care as there was a significant concern for their safety and wellbeing, which continued to be a concern throughout the investigation. Due to those concerns, the children remained in foster care at case closure.

OCFS Review Results:
ACS immediately initiated their investigation, spoke to the source of the report and completed a CPS history review. Interviews were completed with the mother and children. The children were seen at their foster home and ACS made efforts to find familial resources. Safety Assessments were completed timely and with accuracy. The Risk Assessment Profile was not consistent with case circumstances as the surviving siblings were previously in foster care. Required notices were provided to the mother.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP was scored inaccurately as the surviving siblings were in the care and custody of substitute caregivers when they were previously placed in foster care.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/28/2023	Sibling, Female, 10 Years	Mother, Female, 36 Years	Excessive Corporal Punishment	Unsubstantiated	Yes
	Sibling, Female, 10 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 36 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
An SCR report was received that alleged the SC and surviving siblings resided with the biological mother. The mother had a history of being physically abusive towards the then 10-year-old surviving sibling. The mother had hit the sibling on her buttocks with her hand or a belt in the past. The most recent incident occurred on 4/27/23, where the mother hit the sibling with a belt buckle in her face, which caused a bruise on the corner of her left eye. The mother did that as a form of punishment because the child used her credit card by mistake to purchase a book bag. The sibling was afraid of her mother. Law enforcement had a history of responding to the home.

Report Determination: Unfounded | **Date of Determination:** 06/23/2023

Basis for Determination:
ACS unsubstantiated the allegations of Inadequate Guardianship and Lacerations/Bruises/Welts against the biological mother regarding the 10-year-old surviving sibling. Interviews were completed and revealed that the family was at a park, and the children were playing tag when the 10-year-old surviving sibling fell and injured herself. The sibling was medically assessed and forensically interviewed. ACS documented that information gathered did not meet the fair preponderance of evidence standard.

OCFS Review Results:
ACS immediately initiated their investigation, spoke to the source of the report and completed a history review. ACS completed a referral to the district attorney's office, and a forensic interview was completed with the 10-year-old sibling. The Risk Assessment Profile was not accurate as the mother had a history of a mental health condition. The RAP was

previously cited during this review for historical case (5/5/25) and will not be recited. The mother named the biological father as a support; however, there was no effort to obtain locating or contact information. Although the sleeping environments were observed, safe sleep was not discussed with the mother.

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

Issue:

Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:

The BF was noted to have been involved regarding the incident and the BM reported he was a support; however, he was not added to the report, notified about the investigation or attempted to be interviewed.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

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

Issue:

Failure to provide safe sleep education/information

Summary:

Though ACS was in the home and documented sleep provisions for the SC, safe sleep education/information was not discussed or provided to the mother.

Legal Reference:

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

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/05/2022	Deceased Child, Male, 2 Days	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:

An SCR report was received that alleged the biological mother gave birth to the subject child on 12/3/22. The then 10 and 7-year-old surviving siblings were in foster care. The mother had provisions for the subject child (crib, food, bassinet, clothing and diapers).

Report Determination: Unfounded

Date of Determination: 02/06/2023

Basis for Determination:

ACS unsubstantiated the allegation of Inadequate Guardianship against the biological mother regarding the subject child as they did not find a fair preponderance of evidence. The mother had appropriate provisions for the subject child, and his needs were met.

OCFS Review Results:

ACS immediately initiated their investigation, spoke to the source of the report and completed a CPS history review.

Interviews and a home assessment were completed. ACS held an initial child safety conference. Sufficient collaterals were contacted, and safe sleep was discussed. The family continued to be monitored through their open foster care case.

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

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

4/20/15-6/10/15 ACS substantiated the allegations of Lack of Supervision against the biological mother regarding the now 12-year-old surviving sibling.

11/13/17-2/10/18 ACS unsubstantiated the allegations of Inadequate Guardianship and Lacerations/Bruises/Welts against an unrelated household member regarding the now 9-year-old surviving sibling.

2/2/18-4/5/18 ACS unsubstantiated the allegation of Educational Neglect against the biological mother regarding the now 12-year-old surviving sibling.

10/28/19-12/20/19 ACS substantiated the allegations of Inadequate Guardianship and Lack of Supervision against the biological mother regarding the now 12-year-old surviving sibling.

2/22/22- 4/6/22 ACS substantiated the allegations of Inadequate Guardianship and Lack of Supervision against the biological mother regarding the now 12 and 9-year-old surviving siblings.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The FASP was 6 days overdue.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent 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: 05/04/2025
Date of placement with most recent caregiver? 06/24/2025

How did the child(ren) enter placement? 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:** 08/24/2024	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 08/28/2024	☒	☐	☐	☐
Was a check completed through the Staff Exclusion	☒	☐	☐	☐

List? **Date:** 08/19/2024				

Additional information, if necessary:
After the incident, ACS immediately removed the SSs from the FM's residence and placed them in a new foster home. The foster home was permanently closed on 8/19/25, with a recommendation to not re-open. The 9yo SS was discharged from foster care and released back to the BM under COS. The 12yo SS was placed with a familial resource.

Foster Care Placement History

2/23/22-2/27/24 ACS opened a court order service case which resulted from an indicated CPS investigation. The investigation revealed the mother left the children home alone unsupervised for several hours. The children could not gain access to their residence and had to flag down emergency responders to open the door. Emergency responders took the children to a nearby hospital. Due to the children's ages and development, they were placed at risk of harm and subsequently removed and placed in foster care. An Article 10 Neglect petition was filed, and an order of protection was issued against the mother in favor of the children. The mother had weekly supervised visitation, she completed anger management, a parenting skills course, a mental health assessment and received counseling. The children were discharged from foster care on 3/16/23 as the mother was stable.

On 5/4/25, ACS conducted an emergency removal regarding the subject child and surviving siblings as the mother was admitted to the hospital for 11 days due to mental health conditions. After the subject child's death, the siblings were immediately removed from the foster mother's residence and relocated to another foster home. The 9yo SS was discharged back to his mother's care under COS and the 12yo SS was placed with a familial resource. The services case remained open at the time of this writing.

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:**
05/05/2025	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	Other	
Specify:	Mother	
Comments:	On 5/5/25, ACS removed the subject child and surviving siblings from the biological mother who was hospitalized due to mental health conditions. Family Court proceedings were pending at the time of this report was written.	

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