Child Fatality Report

Report Identification Number: BU-25-009

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

Issue Date: Sep 23, 2025

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

- ☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- ☐ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.
- ☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- ☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 05/23/2025
Initial Date OCFS Notified: 05/23/2025

Presenting Information

An SCR report was received on 5/23/25, at approximately 2:30AM, that alleged the 3-month-old subject child woke crying from where he had been asleep in his basinet. The father brought the subject child to the living room while the mother went back to sleep. Sometime between 7:00AM and 8:00AM the father put the subject child back in the bassinet and then left the home. The mother woke around 8:30AM; however, she did not check on the subject child until 12:20PM, at which time the subject child was cold and not breathing. The mother called 911 at 12:29PM and performed CPR until EMS arrived at 12:35PM. EMS continued to perform CPR until 12:55PM, at which time the subject child was pronounced deceased. The subject child was an otherwise healthy child, and the mother and father did not have an explanation for his death.

Executive Summary

Erie County Department of Social Services (ECDSS) received an SCR report concerning the death of the 3-month-old male subject child. At the time of his death, the subject child resided with the subject mother, subject father, and 3-year-old surviving sibling. The surviving sibling's father resided at his respective residence. The subject father's other children, the 6 and 5-year-old surviving siblings, resided in their respective residence.

At the time the SCR report was received, there was an open Preventive Services Case regarding the subject father, the 6 and 5-year-old surviving siblings, and their mother due to the surviving sibling's mother allowed the subject father to have access to the 6 and 5-year-old surviving sibling and on one occasion the subject father held the 5-year-old surviving siblings head under water. ECDSS filed an Article 10 neglect petition, and the surviving siblings were placed under a 1017 placement.

ECDSS learned that the subject father was caring for the subject child when he abruptly left the home. The subject mother checked on the subject child and found him in his bassinet unresponsive. She called 911 and began CPR. EMS arrived and took over life-saving measures and transported the subject child to the hospital where he was pronounced deceased.

The medical examiner performed an autopsy, and the preliminary results determined the subject child sustained a subdural hemorrhage and bilateral optic nerve hemorrhage and the combination of the two was indicative of blunt trauma. Law enforcement had an open investigation and although they continued to investigate, they were waiting for the final autopsy report to be completed before making an arrest. The subject father told law enforcement that he noticed the subject child was unresponsive before he left the home.

ECDSS provided the family with bereavement resources and information for burial assistance.

PIP Requirement

For citations identified in historical cases, ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) ECDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ECDSS 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 allegations were appropriately determined.

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 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: 05/23/2025 **Time of Death:** 12:55 PM

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

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 12:35 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

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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)

LDSS Response

ECDSS began their investigation immediately, contacted the source, and completed a CPS history review. ECDSS contacted the DA, ME, and CAC. ECDSS determined the 6 and 5yo SSs were safe in 1017 placement. ECDSS made a safety plan for the 3yo SS to remain in the care of the MA. ECDSS filed an Abuse petition, the SS was placed under 1017 placement with the MA, and a full stay away order of protection was issued against the SF in favor of the SS.

The SM reported the SF arrived home at 1:31AM and the SM told him “not to mess with” the SC because he was sleeping. She went to the bathroom, and heard the SC start to cry. She believed the SF woke the SC. She told the SF he needed to calm the SC because she had to sleep to wake up early. At 2:32AM, the SC was still crying, and around 3:00AM, the SF brought the SC into the living room. That was the last time the SM saw the SC alive.

At 7:00AM, the SF returned to the bedroom and placed the SC, wrapped in a blanket, in the bassinet. The SM did not hear the SC and assumed he was asleep. The SM went to check the SC, and the SF told her the SC was asleep and to leave him alone. When the SF got into bed, he asked the SM to move over so he could sleep next to the bassinet. This was unusual as the SM always slept next to the bassinet. The SM fell asleep until about 8:00AM, when the MGM arrived with the SS. After getting the SS settled, the SM went back into the bedroom and saw the SF was awake and looking at the SC. She stated it was normal for the SC to sleep until 12:00PM if he had eaten. The SM woke a few more times, and each time the

SF was over the bassinet checking on the SC. The SM thought "he was just being a father." The SM got up to check on the SS and when she returned to the bedroom the SF, who had been checking on the SC, got up and left the room. The SM assumed the SF went to the bathroom; however, she realized he had left the home. The SM checked on the SC and found him on his back, with his face discolored with purple blotches. The SC was no longer swaddled in his blanket, and he was cold and limp. The SM immediately began CPR and called 911. Later the same day, the SF sent the SM a message that stated he noticed the SC did not look right, and he got scared and left.

The SM reported it was normal for the SF to come home in the middle of the night and want to play with the SC. The SF "would always mess with the baby." When the SC would cry, the SF would cry back in an aggressive manner. The SF would say things like "it is good for his lungs to have a good cry" and tell the SM she "jumps to sooth the baby too fast." The SM stated the SF believed he was making the SC stronger and that she could not believe the SF would hurt the SC; however, he was the only one who could have. The SM stated, looking back on it, the SF was acting differently when he came back into the bedroom, and she should have realized something was wrong.

Based on the SS's age and development, she was unable to be interviewed. ECDSS spoke with the MGM, MGF, and MA. ECDSS made diligent efforts to contact the SF; however, were unsuccessful.

ECDSS spoke with LE, EMS, and the fire department. The fire department was first to arrive and found the SM performing CPR on the SC in the bedroom. They moved the SC to the living room couch to continue efforts. The SC was cold and stiff. The fire department reported the scene did not match the SM's description of events and the whole situation felt "weird." The SC had bruises that were consistent with someone having their hand over his mouth. LE spoke with the SM, who told them the SF would scare the SC on purpose because he was trying to get the SC's lungs to develop. An EMS provider reported it appeared the SC had been dead for several hours due to his limbs being cold. LE and three EMS providers mentioned red marks on the SC's face.

ECDSS contacted all appropriate collaterals, completed a thorough investigation, and took appropriate action to maintain the SS's safety.

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? Yes

Comments: Erie County Department of Social Services has an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
071957 - Deceased Child, Male, 3 Month(s)	071958 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated

071957 - Deceased Child, Male, 3 Month(s)	071959 - Father, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
071957 - Deceased Child, Male, 3 Month(s)	071958 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated
071957 - Deceased Child, Male, 3 Month(s)	071959 - Father, Male, 27 Year(s)	DOA / Fatality	Substantiated
071960 - Sibling, Female, 3 Year(s)	071958 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
071960 - Sibling, Female, 3 Year(s)	071959 - Father, Male, 27 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	☒	☐	☐	☐

Explain:
The Risk Assessment was completed accurately. Appropriate services were provided. ECDSS filed an Abuse petition, and the 3yo SS was placed in the MA's care under a 1017 placement.

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:
It was determined the SC sustained severe injuries while in the care of the SM and SF. At the time of this writing, neither

the SM nor the SF provided a reasonable explanation for the injuries. It was determined the 3yo SS was unsafe in the care of the SM and she was placed under 1017 placement with her MA.

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:**
05/28/2025	There was not a fact finding	There was not a disposition
Respondent:	Mother Female 27 Year(s)	
Comments:	ECDSS filed an Abuse petition against the SF and SM and asked that the 3yo SS be removed. A remand was granted, and the 3yo SS was placed under 1017 placement with her MA. The SM was granted supervised visits, and the SF (PS to the 3yo) was allowed no contact.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/28/2025	There was not a fact finding	There was not a disposition
Respondent:	Father Male 27 Year(s)	
Comments:	ECDSS filed an Abuse petition against the SF and SM and asked that the 3yo SS be removed. A remand was granted, and the 3yo SS was placed under 1017 placement with her MA. The SM was granted supervised visits, and the SF (PS to the 3yo) was allowed no contact.	

Have any Orders of Protection been issued? Yes	
From: 05/28/2025	**To:** Unknown
Explain: A Full Stay Away Order of Protection was issued against the SF (PS to the 3yo SS) in favor of the 3yo SS.	

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 family was offered bereavement resources and were in the process of finding a therapist for the 3yo SS. It was unknown if the family utilized burial assistance. The 3yo SS was placed under 1017 placement with the MA and a Preventive Services Case was opened.

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 family was provided with bereavement resources.

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 family was provided with bereavement resources and information on burial assistance.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/28/2024	Sibling, Male, 5 Years	Father, Male, 26 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 4 Years	Father, Male, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 5 Years	Other Adult - SS's BM, Female, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Years	Other Adult - SS's BM, Female, 26 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 5 Years	Father, Male, 26 Years	Lack of Supervision	Substantiated	

Report Summary:
An SCR report was received alleging that the SF was physically aggressive to others while in the presence of the SSs. The SF became mad and put his hands around the uncle's throat. The SSs were scared. The SF would get angry and leave the home, leaving the 5yo SS home alone for unknown periods of time. The 5yo SS reported being scared and crying. The 5yo was too young to be unsupervised for any period. On one occasion, the SF put the 4yo SS's head under water, and the 4yo SS was scared that he was drowning.

Report Determination: Indicated | **Date of Determination:** 09/30/2024

Basis for Determination:
The allegations of IG and LS were substantiated. Despite being aware of the prior court proceedings and concerns, including DV committed by the SF against the SS's BM and an OP being in effect until 2027, the SS's BM allowed the SF unsupervised access to the SSs. During that access, the SF became angry with the 4yo SS and stuck his head under water. The 4yo SS believed he was drowning. The 5yo SS expressed fear of the SF and his BM. ECDSS planned with the SS's BM, that she would not allow the SF any further access to the SSs; however, that same day the SF was with the SSs. An Article 10 neglect petition was filed and the SS's BM agreed to a 1017 placement.

OCFS Review Results:
ECDSS began their investigation within 24 hours. Although, ECDSS sought legal intervention and asked for the SSs to be removed and for an OP, there was a significant 3-month gap in casework activity, during which time the SSs were not being monitored for safety. The 4yo SS was not asked about the allegation in the SCR report until 8/19/24, at which point, his disclosure led to court intervention. Despite the allegations being true, between 5/16/24 and 8/15/24, the SSs were not being monitored for safety and the SF had access to them. ECDSS did not attempt to locate the SF, who was the subject of the report, until 4 months into the investigation. The case was closed 3 months overdue.

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

Issue:

Timeliness of Determination

Summary:

ECDSS has the responsibility of making a determination within 60 days of receiving an SCR. This case was overdue to be closed by 95 days and ECDSS did not ask the SSs about the allegations until after the case was already overdue to be closed.

Legal Reference:

SSL 424(7);18 NYCRR 432.2(b)(3)(iv)

Action:

ECDSS will make a determination of either "indicated" or "unfounded" within 60 days after receiving the report.

Issue:

Overall Completeness and Adequacy of Investigations

Summary:

There was a 3-month gap in casework activity from 5/16/24-8/15/24, when safety was not being monitored, the 4yo SS was not asked about the allegation until 8/19/24, and ECDSS did not attempt to locate the SF until 4 months after receiving the SCR report.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

ECDSS must continue to gather information to reassess safety of the child(ren), throughout the time child welfare staff are involved with the family and until the case is closed, because safety is not static. (CPS Manual Chapter 6 section D page D-1 and D page D3.)

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

An investigation was opened from 12/26/21-1/24/22 with allegations of IG and PD/AM being unsubstantiated against the SM regarding the then 1-day old SS.

An investigation was opened from 3/2/20-4/29/20 with allegations of IG, B/S, FX, II, and LMC regarding the then 21-day-old SS and the allegation of IG regarding the then 1yo SS being substantiated against the SF and the SS's BM.

Required Action(s)

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

Issue:	Adequacy of Child Protective Services casework contacts (open services)
Summary:	There were insufficient face to face contacts made with the family, as ECDSS did not make at least one face to face contact with each person on the case or visit each home every month.
Legal Reference:	18 NYCRR 432.2(b)(4)(vi)
Action:	In cases where the child protective service is the primary service provider to children named in indicated child protective services cases and their families, ECDSS must make at least two separate face-to-face contacts per month with the subject(s) and other persons named in the report, one of which one must take place in the subject's home.

Preventive Services History

On 9/26/24, the current Preventive Services Case was opened. On 9/27/24, an Article 10 neglect petition was filed against the SF and the SS's BM due to the SF holding the then 4yo SS's head under water.

A Preventive Services Case was opened from 3/10/20-11/15/23 due to the then 21-day-old SS sustaining serious injuries, including second-degree burns to the side of his abdomen, neck, ear, nose, chin, and other body parts, a superior labial frenulum laceration, a clavicle fracture, displaced rib fractures, and contusions to his brain, including a hemorrhaging on the brain. An Abuse petition was filed, and both SSs were placed in foster care on 3/6/20. The SF and SS's BM had supervised visitation and were ordered to comply with services such as, parenting, DV, and MH. ECDSS attempted to have the SF and SS's BM rights terminated; however, this request was denied by family court. The SS's BM was eventually able to separate herself from the SF and gain stable housing. On 12/20/22, the SSs were released into their BM's care, as she was compliant with services. The SF was not compliant with services and had minimal contact with the SSs. When the SSs were returned to their BM, she agreed to file for custody, with a stipulation that the SF only have supervised access to the SSs; however, she never filed for custody and allowed the SF access to the SSs.

Foster Care Placement History

On 3/6/20, the then 21-day-old and 1yo SSs were placed in foster care after ECDSS filed an Abuse petition against the SF and the SS's BM due to the 21-day-old SS sustaining severe injuries. The SSs were returned to their BM on 12/20/22; however, they were placed back with their previous foster mother under 1017 placement on 9/27/24.

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:**
09/27/2025	There was not a fact finding	There was not a disposition
Respondent:	Father Male 27 Year(s)	
Comments:	On 9/27/24, ECDSS filed an Article 10 neglect petition against the SF and SS's BM. The SS's BM allowed the SF access to the SSs and the SF physically assaulted other adults in the SS's presence and	

	held the then 4yo SS's head under water. The SS were placed under 1017 placement with their previous foster mother.

Criminal Charge: Assault	**Degree:** 2		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/03/2024	3yo SS's BF	Unknown	Unknown
Comments:	The 3yo SS's BF was charged with Assault 2nd: Injure Victim 65 or Older, Menacing 3rd, and Attempted Robbery 3rd.		

Criminal Charge: Assault	**Degree:** 3		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
10/29/2024	3yo SS's BF	Unknown	Unknown
Comments:	The 3yo SS's BF was charged with Assault 3rd, Burglary 2nd, Harassment 2nd, and Criminal Obstruction of Breathing/Blood Circulation- Apply Pressure.		

Criminal Charge: Assault	**Degree:** 3		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
07/25/2024	3yo SS's BF	Unknown	Unknown
Comments:	The 3yo SS's BF was charged with Assault 3rd, Harassment 2nd, Resisting Arrest, and Drinking Alcohol or Using Cannabis in a Motor Vehicle.		

Have any Orders of Protection been issued? Yes	
From: 12/17/2024	**To:** 12/17/2026
Explain: The 3yo SS's BF was issued an OP in favor of the SM due to DV.	
From: 01/05/2022	**To:** 01/23/2027
Explain: The SF was issued an OP in favor of the 6 and 5yo SS's and their BM due to a DV incident that occurred in October 2021.	

Additional Local District Comments

We appreciate the opportunity given to us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation

was conducted appropriately and that there are no required actions related to the fatality. We must, unfortunately, concur with the citations and required actions relating to the historical CPS investigation dated April 28, 2024. In addition, we must also concur with the citation and required action relative to the open services case.

As a corrective action related to the above identified citations, the respective caseworkers as well as their lines of supervision will be advised of the required actions and the need to ensure compliance with such. In addition, these issues will be addressed at our monthly supervisor meetings.

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