Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-055

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

Issue Date: Oct 27, 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: 15 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 05/29/2025
Initial Date OCFS Notified: 06/05/2025

Presenting Information

An SCR report was received on 6/5/25, alleging that on 5/29/25, the 15-year-old subject child was found unresponsive by the subject mother. The parent substitute called 911 at 4:36AM and EMS responded. The subject child was pronounced deceased at the scene at 5:15AM and transported directly to the medical examiner's office. The subject child had medical issues. The subject child suffered a significant head trauma and bleeding around the brain at the hands of the subject mother at the age of 4 months. The subject child had been deteriorating for months prior to his death and was seen medically for an electrolyte imbalance as result of lack of food and proper hydration. The subject child was somewhat ambulatory but had been crawling around on the ground and ingesting inanimate objects such as pieces of plastic and staples. The subject child had a history of self- harm.

Executive Summary

This report concerns the death of the 15-year-old male subject child that occurred on 5/29/25. On 6/5/25, the New York City Administration for Children's Services (ACS) received an SCR report with allegations of Inadequate Guardianship, and DOA/Fatality against the subject mother and parent substitute regarding the subject child. At the time of the child's death, he resided with his mother, 13-year-old surviving sibling and twin 3-year-old surviving siblings. The SC also had an 18-year-old surviving sibling who resided in another state. The parent substitute was in the home regularly, but he did not reside in the home; however, he did have caregiving responsibilities for the subject child. The safety of the surviving sibling was assessed within 24 hours of receiving the fatality report.

Through a joint investigation with law enforcement, it was learned that on 5/29/25, at around 4:00AM, the subject child was found unresponsive by the subject mother. The subject mother alerted the parent substitute and called 911. The subject mother and parent substitute administered cardiopulmonary resuscitation until Emergency Medical Services arrived. The subject child was pronounced deceased on scene at 5:15AM. Emergency Medical Services transported the subject child directly to the medical examiner's office.

ACS was able to see the surviving siblings virtually via video as they were in another state with their maternal grandmother where they were deemed safe. ACS interviewed the verbal surviving sibling who was able to corroborate the subject mother's timeline of events. The 3-year-old surviving siblings were unable to be interviewed due to developmental delays and they were non-verbal.

ACS contacted the biological father of the subject child. He was unable to provide any additional information regarding the fatal incident as he has had no contact with the subject child since 2021.

ACS spoke with the medical examiner's office. The medical examiner reported that the autopsy was pending further studies. She could not provide an exact timeframe for when the results would be in; however, noted it would take several months. The medical examiner shared that the subject child weighed 44 pounds and the child's growth was stunted, due to Shaken Baby Syndrome sustained at 4-months-old. The medical examiner found no broken bones: however, there was bruising and scrapes on the subject child's shoulders, knees, elbows, and legs. The ME noted the scrapes, and bruising could have been caused from blunt force trauma; however, the mother reported the subject child would bang himself on objects causing self-injury. The medical examiner reported that the subject child had pieces of plastic and staples in his

intestines, and he appeared to be dehydrated. At the time of this writing, the cause and manner of death was still pending.

At the time of this writing the case record did not reflect if law enforcement filed any charges or made any arrests. It was unknown if the case was still open.

ACS made the appropriate determination and substantiated the allegations against the subject mother and parent substitute regarding the death of the subject child. A remand of the surviving siblings was sought and granted by the court. The surviving siblings were removed from the mother's care on 6/10/25 and placed in foster care. A full stay away order of protection was issued against the mother, and she was granted supervised visitation with the surviving siblings. It is unclear why ACS did not file a family court petition against the parent substitute as the allegations against him were substantiated and he was not deemed an appropriate caregiver.

ACS immediately arranged for trauma-based services for the 13-year-old surviving sibling. Bereavement services were offered; however, the family declined services. The surviving siblings are currently in a kinship foster home with their maternal aunt in another state.

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:
Based upon the information obtained throughout the investigation, ACS made the appropriate decision to substantiate the allegations.

Was the decision to close the case appropriate? Yes

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: 05/29/2025 **Time of Death:** 05:15 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 04:36 AM
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	15 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	13 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Other Household 1	Other Adult - Parent Substitute	Alleged Perpetrator	Male	34 Year(s)

LDSS Response

On 6/5/25, ACS received an SCR report regarding the death of the 15-year-old SC which occurred on 5/29/25. ACS initiated their investigation within 24 hours and notified the district attorney, communicated with the medical examiner's office, and coordinated their efforts with law enforcement. ACS contacted the source of the report, completed a CPS history check, and immediately learned there were three surviving siblings ages 13yo and 3yo twins.

ACS completed an interview with the SM outside of the family residence as ACS was denied access to the home. On the day before the death, 5/28/25, the SM reported they all woke up at the same time around 7:30AM, the PS had already left for work at around 7:00AM. They all remained in bed watching television. The SM advised that the SSs sleep in bed with her and the SC regularly sleeps on the floor, with a heated blanket as he has severe developmental disabilities and had rolled off the bed in the past, so they don't put him in bed. They ate breakfast at 10:00AM and continued to watch television. The SM stated that they all took a nap from 12:00PM-2:00PM. The SC remained on the floor, under the heated blanket from 7:30AM-2:00PM. The PS arrived at the residence at 2:00PM and dinner was prepared, and the family ate dinner. The SC was not interested in dinner, so the SM gave him a honey bun, his favorite food. After dinner, she left the children in the care of the PS while she attended a standing medical appointment where she receives treatment for a chronic medical condition. She returned home at 11:00PM. While she was gone, the 13yo SS administered the SC's medication to him. They all prepared for bed, and they all went to sleep in the bed and the SC was on the floor. The SM woke up on 5/29/25, at 2:30AM to use the bathroom and she checked on the SC. She noticed he was drooling, and she wiped his mouth. The SC opened his eyes and looked at her. She went back to sleep at 3:15AM and then woke up at 4:00AM again to check on the SC and she found him unresponsive on the floor. The SM alerted the PS who picked the SC up and placed him on the bed where she attempted to administer CPR while the PS called 911. The PS took over CPR until EMS arrived and the SC was pronounced deceased at 5:15AM at the scene.

The SM denied that there could have been staples or plastic in the SC's intestine as they do not own a stapler. The SM advised that the SC suffered from seizures, was non-verbal and he was somewhat mobile, but he did use a wheelchair. The SM reported the SC had sensory issues and would often bang his head, scratch himself, and inflict bruising to himself. At the time of the SC's death, he weighed only 44 pounds. The SM advised that there was always concern for the SC's weight as he never weighed over 55 pounds since birth.

ACS completed interviews with the PS and the 13yo SS who corroborated the SM's timeline of events. The SS reported she was responsible for feeding the SC and meeting his basic needs. The SS advised that the SC had a cold in mid-May 2025 that he never fully recovered from. The SS reported that was when the SC started declining. He stopped eating well, he stopped walking and had very low energy. She told the SM that the SC was not eating, and the SM advised that the SS keep the SC hydrated. The SM did not seek medical attention for the SC. Both the SS and PS advised that they helped care for the SC when the SM had to attend her treatments. The SS did not disclose concerns in the home, and she denied that food was withheld from her or her siblings.

It was reported that the SC had three missed medical appointments in March and April 2025 to address his mobility issues, electrolyte imbalance, and poor appetite.

The SM was offered fatality related services that were declined. On 6/10/25, the surviving siblings were removed from the care of the SC and placed in foster care. A Family Services Stage (FSS) was opened for the family on 6/5/25.

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 New York City 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
072373 - Deceased Child, Male, 15 Year(s)	072378 - Other Adult - Parent Substitute, Male, 34 Year(s)	DOA / Fatality	Substantiated
072373 - Deceased Child, Male, 15 Year(s)	072378 - Other Adult - Parent Substitute, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072373 - Deceased Child, Male, 15 Year(s)	072378 - Other Adult - Parent Substitute, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
072373 - Deceased Child, Male, 15 Year(s)	072374 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
072373 - Deceased Child, Male, 15 Year(s)	072374 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072373 - Deceased Child, Male, 15 Year(s)	072374 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
072375 - Sibling, Female, 13 Year(s)	072378 - Other Adult - Parent Substitute, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
072375 - Sibling, Female, 13 Year(s)	072374 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
072376 - Sibling, Female, 3 Year(s)	072378 - Other Adult - Parent Substitute, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
072376 - Sibling, Female, 3 Year(s)	072374 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
072377 - Sibling, Male, 3 Year(s)	072378 - Other Adult - Parent Substitute, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
072377 - Sibling, Male, 3 Year(s)	072374 - Mother, Female, 34 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:
ACS was granted a removal of the SSs in family court.

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:
06/13/2025	There was not a fact finding	There was not a disposition
Respondent:	Mother Female 34 Year(s)	
Comments:		

Have any Orders of Protection been issued? Yes

From:	To:
06/13/2025	Unknown

Explain:
The SM was granted supervised visitation with the SS's.

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:
Bereavement services were offered to the family, but they declined. ACS immediately made a referral for trauma-based counseling for the 13yo SS.

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:
Bereavement services were offered to the family, but they declined. ACS immediately made a referral for trauma-based counseling for the 13yo SS.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/12/2023	Deceased Child, Male, 13 Years	Mother, Female, 32 Years	Burns / Scalding	Unsubstantiated	Yes
	Deceased Child, Male, 13 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 32 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 13 Years	Mother, Female, 32 Years	Lack of Supervision	Substantiated	

Report Summary:
An SCR report was received on 11/12/23, alleging that the SC age 13, had a large 2nd degree burn to the lateral aspect of his left buttock. The SC was a special needs child. The SM could not provide an explanation for how the SC sustained the injury. As a result, the injury was considered suspicious.

Report Determination: Indicated | **Date of Determination:** 01/11/2024

Basis for Determination:
ACS substantiated the allegations of IG, LM, and LS and unsubstantiated the allegation of B/S against the SM regarding the 13yo SC. There was a fair preponderance of evidence found to substantiate that the SM failed to provide a minimum standard of care regarding the SC when he sustained a second to third-degree burn to his buttocks. The SM did not seek medical care or provide an explanation for the injury. There was not a fair preponderance of evidence to substantiate the allegation of B/S as the mother treated the injury herself and she did follow-up with treatment at a local hospital.

OCFS Review Results:
ACS immediately initiated their investigation, spoke to the source of the report and completed a CPS history check. Interviews were completed with the BM and children as well as a home assessment. ACS completed sufficient collateral contacts, Community-based services were discussed, and a preventive services case was opened for the family. The biological father was not notified or interviewed despite being identified in two progress notes dated 11/13/23, and 11/17/23.

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

Issue:

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

Summary:

The biological father of the SC was not contacted or interviewed regarding the SCR report, despite being identified as the biological father in two progress notes dated 11/13/23, and 11/17/23.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians.

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.

Issue:

Case record contains information that is relevant, useful, factual and objective

Summary:

ACS correctly identified and documented the allegation of IG regarding the 1yo twin SSs in the investigation determination narrative; however, the CONNECTIONS system does not reflect the allegation of IG was added or substantiated.

Legal Reference:

18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:

ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

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.

[redacted]

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

10/11/18-12/7/18 the allegations of IG and LMC were Sub against the SM and BF re: the 11yo SS.

1/17/19-3/15/19 the allegation of IG was Sub against the BF re: the 9yo SC.

1/17/19-3/15/19: the allegations of IG, LM, XCP, L/B/W, PD/AM, and C/T/S were Unsub against the BF re: the 9yo SC, 7yo SS, and 11yo SS.

1/17/19-3/15/19 the allegations of IG and LM were Sub against the SM re: the 9yo SC.

1/17/19-3/15/19 the allegation of IG was Unsub against the SM re: the 11yo SS, 7yo SS and 9yo SC.

5/14/19-7/21/19 the allegations of IG and L/B/W were Sub against the BF re: the 11yo SS.

07/05/19-7/12/19 the allegation of IG was Sub against the BF re: the 12yo SS, 7yo SS, and 9yp SC.

8/20/19-10/14/19 the allegations of IF/C/S and IG were Unsub against the SM re: the 12yo SS, 7yo SS, and 9yp SC.

11/1519-1/14/20 the allegations of IG and IF/C/S were Unsub against the SM re: the 9yo SC and 7yo SS.

1/14/20-3/12/20: the allegations of XCP, IG, L/B/W and LS were Sub against the BF re: the 13yo SS.

1/14/20-3/12/20 the allegation of IF/C/S was Unsub against the BF re: the 13yo SS.

1/14/20-3/12/20 the allegation of PD/AM, IG and LS were Unsub against the SM re: the 13yo SS, 10yo SC and 8yo SS.

10/25/20-12/16/20 the allegations of PD/AM and IG were Sub against the SM re: the 13yo SS, 10yo SC, and 8yo SS.

Known CPS History Outside of NYS

New Jersey CPS history:

5/10/10: The 4-month-old SC fell off the bed at 2:30AM and the SM did not take the SC to the ER until later in the day. The SC was seen by pediatrics ER medical staff and the SC was diagnosed with Shaken Baby Syndrome. Both the SC and 2yo SS were removed from the home and placed in foster care. The case was indicated.

11/8/13: The 6yo SS was hit in the eye and noted to have behavioral issues. The child did not disclose who hit him. The case was closed with no findings.

3/16/16: The 8yo SS refused to go home from school. The school arranged for transportation so the BF could pick the SS up from school. The case was closed with no findings.

5/13/16: The 6yo SC went to school with bruising on his eye with an open gash. The child was supposed to wear a helmet to stop him from banging his head. The SM removed the helmet as she felt it was adding bruising to the SCs head. The SM was offered services but declined. The case was closed with no findings.

6/15/16: The 6yo SC was supposed to be on anti-seizure medication and was seen with an abrasion to his forehead. The child banged his head and was supposed to wear a helmet. The SM did not refill the medication. The case was unfounded.

11/13/16: It was alleged that the 9yo SS was left home alone. The MGM denied the child was left home alone. The case was closed with no findings.

11/14/16: A referral was made for the 6yo SC who was not potty trained, and the SM did not have pampers.

Preventive Services History

11/20/18-5/10/22: a preventive services case was opened for the family regarding concerns that the 16yo SS had a Lego lodged in his ear since January of 2018. The SM and BF failed to address the issue. The SM and BF reported that a lapse in insurance hindered them from attending the scheduled medical appointment for the child to have the Lego removed.

11/28/23-1/2/25: a preventive services case was opened due to the following concerns: On 11/12/2023, the 13yo SC sustained a 2nd degree burn to the lateral aspect of his left buttock. The SC was a special needs child and was nonverbal. The SM had no explanation for how the SC sustained the injury. As a result, the injury was suspicious in nature. The SM reported noticing injury while changing the SCs diaper. The SM did not seek immediate medical attention for the burn.

The SM reported the SC could have burned himself on a radiator in the home. The SM reported that she had a medical condition for which she received treatment three times per week. The SM reported that there were times when she was overwhelmed; however, had support when she needed it.

Foster Care Placement History

As a result of the fatality, a Family Services Stage (FSS) was opened as the children were removed from the care of the mother and placed in foster care. The case remains open.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

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