Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-074

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

Issue Date: Dec 22, 2025

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 09/02/2024
Initial Date OCFS Notified: 07/22/2025

Presenting Information

An SCR report was received on 7/22/25, which alleged that on 9/2/24, the parent substitute intentionally placed the child into a bathtub with scalding hot water for unknown reasons. As a result, the child sustained third-degree burns to his buttocks, genitals, and upper thighs. The child developed respiratory complications from the burns, which resulted in his death on 9/2/24. The mother was present and failed to adequately intervene to protect the child.

Executive Summary

This report concerns the death of a two-year-old subject child that occurred in September 2024. The death was originally reported on 9/3/24 to the Administration for Children's Services (ACS). At that time, ACS notified the Office of Children and Family Services (OCFS) of the death through the required 7065-Agency Reporting Form. OCFS issued a fatality report (NY-24-085) at that time. OCFS issued an additional fatality report (NY-25-018) as more new information regarding the child's death and previously investigated allegations were made to the SCR. The family was receiving preventive services, and there was no suspicion that the child died as a result of abuse or maltreatment.

On 2/18/25, new information regarding the child's death and previously investigated allegations of Sexual Abuse, Inadequate Guardianship, and Burns/Scalding were made to the SCR, which generated a new fatality report. At the time of his death in 2024, the subject child resided at home with his mother, parent substitute, maternal aunt, and siblings, ages 9, 6, 4 years, and 3-months-old.

This fatality report is being written in response to information received in the 7/22/25 SCR report after the medical examiner's findings ruled the death of the subject child a homicide. The findings indicated that the subject child died due to respiratory complications following a remote scalding burn to the torso.

ACS completed casework and collateral contacts and learned that on 8/25/24, the subject child was at home eating dinner when he went into cardiac arrest. He was transported to the hospital, placed on a ventilator, and listed in critical condition. The child sustained significant brain damage, and the mother subsequently decided to have him removed from the ventilator. He was pronounced deceased on 9/2/24.

The mother, parent substitute, and surviving siblings have since relocated out of state. ACS contacted the child welfare agency in the state where the family is currently residing and requested a welfare check, which was completed.

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

Explain:
The safety of the children was assessed in the state where they resided.

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

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
There was detailed documentation of a supervisory consult and case planning throughout the investigation.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	Conversations with the mother and PS were lacking key safety-related questions. ACS documented in the investigation conclusion Safety Assessment that a safety plan was in place; however, there were no discussions with the mother or PS regarding this.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS will document all applicable actions and considerations with respect to safety planning, including but not limited to: including all family members when devising the plan and adequately monitoring the plan. ACS will incorporate key safety-related questions as they pertain to case circumstances.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There was no documentation that ACS spoke or attempted to speak to the medical examiner who performed the autopsy on the SC to confirm the information in the final report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)

Action:	ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/02/2024 **Time of Death:** Unknown

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Month(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)

LDSS Response

On 7/22/25, ACS received a report regarding the death of the SC, which occurred on 9/2/24. ACS initiated its investigation within 24 hours and reached out to law enforcement. ACS conducted a CPS history check regarding the family, which revealed two prior investigated fatalities. At the time this report was received, the subject mother, the parent substitute, and the children had relocated out of state. ACS initially conducted a video chat with the family and assessed the safety of 4 of the surviving siblings on 7/22/25.

ACS spoke with the mother by phone on 7/23/25 and learned that the family had relocated out of state. The mother informed ACS that she had since given birth to another child on 6/23/25. ACS questioned the mother regarding the circumstances of the SC's death. The mother reported that the SC was at home with her and the SS, eating dinner, when he began to choke, and 911 was contacted. The SM stated that the PS was not home at the time of the fatal incident.

ACS spoke with the PS by phone on 9/18/25. He confirmed that he was not present when the SC sustained burns in the bathtub or at the time of the fatal incident.

ACS contacted the child welfare agency in the state where the family was residing and requested a face-to-face home visit. The home visit was conducted, and the five SS were deemed safe in the home. The out-of-state agency confirmed that the school-aged children were attending school.

At the close of the investigation, no criminal charges were brought against either parent. ACS did not speak to the medical examiner who performed the autopsy to address the contradictory information reported. The allegations of DOA/Fatality, Inadequate Guardianship, and Burns/Scalding were substantiated against the mother. The Investigation Conclusion Narrative stated, "while these events had been previously investigated, there is new information that the medical examiner has determined the SC's cause of death to be a homicide. Because it is undisputed that the SM was in the home and left the SC in a bathtub, and the medical examiner determined the cause of death of homicide, the allegations are substantiated against the SM".

Official Manner and Cause of Death

Official Manner: Homicide

Primary Cause of Death: From an injury - external cause

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
072704 - Deceased Child, Male, 2 Year(s)	072705 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated

072704 - Deceased Child, Male, 2 Year(s)	072705 - Mother, Female, 27 Year(s)	Burns / Scalding	Substantiated
072704 - Deceased Child, Male, 2 Year(s)	072705 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
072704 - Deceased Child, Male, 2 Year(s)	072706 - Mother's Partner, Male, 30 Year(s)	DOA / Fatality	Unsubstantiated
072704 - Deceased Child, Male, 2 Year(s)	072706 - Mother's Partner, Male, 30 Year(s)	Burns / Scalding	Unsubstantiated
072704 - Deceased Child, Male, 2 Year(s)	072706 - Mother's Partner, Male, 30 Year(s)	Inadequate Guardianship	Unsubstantiated

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?	☐	☒	☐	☐
Pediatrician	☐	☐	☐	☒
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?	☒	☐	☐	☐
Explain: Safety decision 5 was chosen on the 7-day Safety Assessment; however, the children's whereabouts were known, and ACS spoke to the mother and conducted a video chat with the SSs.				
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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

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

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

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)
02/19/2025	Deceased Child, Male, 2 Years	Mother's Partner, Male, 30 Years	DOA / Fatality	Unsubstantiated	Yes
	Deceased Child, Male, 2 Years	Mother's Partner, Male, 30 Years	Burns / Scalding	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother's Partner, Male, 30 Years	Sexual Abuse	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother's Partner, Male, 30 Years	Sexual Abuse	Unsubstantiated	
	Sibling, Male, 9 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Months	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged that in September 2024, when the child was two years old, the parent substitute burned the child's genitals, buttocks, and upper thighs with scalding hot water. The child sustained third-degree burns and was taken to the hospital for medical care. The child succumbed to his injuries due to the severity of the burns and died in September 2024. Prior to the child's death, the parent substitute sexually abused the child and the 4-year-old sibling by anally penetrating both children. The mother was aware that the parent substitute sexually abused the children but still allowed the stepfather to act as a caretaker for the 9, 6, 4, 2, and 8-month-old children.

Report Determination: Unfounded | **Date of Determination:** 04/14/2025

Basis for Determination:
ACS learned that the family relocated out of state. Video interviews of the children and adults were conducted. The PS denied the allegations, stating that he was not home at the time of the fatal incident. The mother stated that she was home with the children at the time and confirmed that the SC choked and became unresponsive, and 911 was contacted.

OCFS Review Results:
ACS initiated the investigation by contacting the source and completing a history check. At the close of the investigation, the SSs were deemed safe in the care of the mother and PS, and no criminal charges were brought against the mother or PS.

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

Issue:

Failure to utilize an approved MDT

Summary:

The case was pre-determined for the assessment of safety and risk because efforts were not made to conduct a joint investigation with law enforcement regarding the new information received in the SCR report.

Legal Reference:

SSL 423(6); SSL 424 (5-a); 10-OCFS-LCM-09

Action:

The Regional Office informed that there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACS will continue to work on this issue and revise the current PIP if deemed necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/06/2023	Deceased Child, Male, 1 Years	Mother's Partner, Male, 28 Years	Sexual Abuse	Unsubstantiated	No
	Sibling, Male, 3 Years	Mother's Partner, Male, 28 Years	Sexual Abuse	Unsubstantiated	
	Deceased Child, Male, 1 Years	Mother, Female, 26 Years	Burns / Scalding	Substantiated	
	Deceased Child, Male, 1 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 1 Years	Mother, Female, 26 Years	Lack of Medical Care	Substantiated	

Report Summary:

An SCR report alleged the parent substitute had been sexually abusing the 1-year-old SC and 3-year-old SS. A subsequent SCR report was received, which alleged the 1-year-old SC sustained 2nd-degree burns from the back of his neck, down his back, and onto the back of his thighs. The mother's explanation was inconsistent with the SC's injuries. The 1-year-old SC required immediate medical treatment, and the mother failed to seek it.

Report Determination: Unfounded | **Date of Determination:** 12/05/2023

Basis for Determination:

ACS conducted forensic interviews, and no disclosures were made regarding the sexual abuse. The parent substitute denied the allegations. The SC was treated for the burns that he obtained while in the bathtub. Medical staff and ACS believed that the SM's story was consistent with this being an accident. The mother did seek medical treatment for the SC.

OCFS Review Results:

ACS initiated the investigation by contacting law enforcement to conduct a joint investigation. Forensic interviews were conducted. ACS opened the case to preventive services to work with the family regarding the medical needs of the SC.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/31/2023	Sibling, Male, 7 Years	Mother, Female, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:

An SCR report was received on 1/31/23, which alleged that the mother put the then 7-year-old SS outside the home from

approximately 1:00PM to 6:00PM as a form of punishment. The child was without a coat and was crying for help. The child was knocking on the door, but the mother refused to let him in.

Report Determination: Indicated	**Date of Determination:** 05/10/2023

Basis for Determination:
The SM informed ACS that on 1/30/23, she disciplined her 7-year-old son by having him stay in the backyard for 15 minutes without a coat. The mother stated that the child was coming in and out of the home. The mother, at times would send the children to the "cold room," which is similar to a storage room, as a form of punishment.

OCFS Review Results:
ACS conducted a HV and interviewed the SM regarding the allegations. The children were observed in the home but were not interviewed. Supervisory directives were not followed. Attempts were not documented to reach the biological fathers of the children. The record did not reflect that ACS attempted to contact the source.

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:
There were no full interviews documented of the SC or SS to assess overall safety and risk. The biological fathers of the children were identified. ACS documented that they would attempt to make contact with the biological fathers; however, no notation in the case record reflected that attempts were made.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
The Regional Office informed that there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACS will continue to work on this issue and revise the current PIP if deemed necessary.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The record did not reflect that the source of the report was contacted.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
The Regional Office informed that there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACS will continue to work on this issue and revise the current PIP if deemed necessary.

[redacted]

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

The family has a history with CPS dating back to 2017.

7/27/17-9/25/17 Allegations of Inadequate Guardianship were substantiated against the mother for the SSs.

2/28/19-4/24/19 Allegations of Inadequate Guardianship were substantiated against the mother for the SSs.

8/4/20-9/30/20 Allegations of Inadequate Food, Clothing, Shelter, and Inadequate guardianship were indicated against the mother for the SSs.

Known CPS History Outside of NYS

There is no known CPS history outside of NY State.

Preventive Services History

8/15/17 - 10/23/17 a family services stage was opened for the mother and SS. At the time, the mother had threatened the younger sibling with a knife, and an order of protection was issued. The mother secured housing, and the preventive case closed.

3/1/19 - 4/1/20 a family services stage was opened after the mother threatened the father of the SS with a knife in the presence of the SSs. An Article 10 neglect petition was filed, and the SSs were placed with the MA. The SSs were returned after the mother completed anger management and batterer's accountability.

8/6/20 - 1/5/21 a family services stage was opened due to the mother's mental state, aggressive behaviors and unstable housing. The preventive case was closed after the mother completed parenting classes and relocated.

10/31/23 a family services stage was opened following a 10/24/23 SCR report. The SC was hospitalized after receiving 2nd-degree burns while in the bathtub. The family services stage remained opened at the time of the SC's death. The family was offered grief counseling services, in addition services were provided to the SS due to his challenging behaviors. The family services stage case was closed on 11/27/24 due to the progress the family made.

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