Child Fatality Report

Report Identification Number: SY-25-020

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

Issue Date: Nov 03, 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: 9 year(s)
Jurisdiction: Oswego
Gender: Male
Date of Death: 05/20/2025
Initial Date OCFS Notified: 05/20/2025

Presenting Information

An SCR report alleged on 05/20/25, the 9-year-old child was brought to the emergency room due to being ill and he experienced a neurological event. After arriving at the hospital, the child died. The mother's explanation regarding the symptoms the child displayed in the days prior to his death was inconsistent with the death.

Executive Summary

This report concerns the death of the 9-year-old child that occurred on 05/20/25. An SCR report was received on the same day with allegations that the child was brought to the hospital due to illness. The child suffered a neurological event, but surrounding circumstances remained unknown. The child subsequently died. The mother's explanation regarding the child's symptoms was inconsistent with the child's passing. There was a 1-year-old surviving sibling who was assessed to be safe. The father was incarcerated and did not have a relationship with the child.

Oswego County Department of Social Services (OCDSS) received the fatality report and coordinated investigative efforts with law enforcement. The outcome of the criminal investigation remained unknown. An autopsy was performed. The autopsy report listed the cause of death as "a complication of acute parainfluenza type 3 and rhinovirus co-infections, including lymphocytic myocarditis and intestinal pneumonia." The manner of death was natural.

The mother and her partner reported that the child was ill in the days leading to his death, so they sought medical attention for him. The child vomited and had a headache. On the day of his death, the child was wobbly, fell to the floor and made incoherent statements. The mother called 911 and the child was transported to the hospital where his condition worsened, and he was pronounced deceased. The mother and her partner reported that the child was fed appropriately and took his medication as prescribed.

OCDSS gathered information from collateral contacts including doctor's offices, the paternal grandparents and school staff. There were no concerns for the mother's care of the child or her ability to obtain medical attention.

OCDSS completed required reports timely and with accuracy. The family was offered bereavement services and funeral assistance. At the time of this writing, the investigation was overdue to be determined and closed. The investigation remained pending.

PIP Requirement

OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS 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?** N/A
- **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?** N/A

Explain:
The case remained open at the time of this writing.

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

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

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

Explain:
The investigation was not determined and closed timely.

Required Actions Related to the Fatality

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

Issue:	Timeliness of Determination
Summary:	OCDSS interviewed the family and collateral contacts, and obtained the autopsy report, yet the investigation remained open at the time of this writing, 126 days after the receipt of the SCR report.
Legal Reference:	SSL 424(7);18 NYCRR 432.2(b)(3)(iv)
Action:	OCDSS will make a determination of either “indicated” or “unfounded” within 60 days after receiving the report.

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 05/20/2025 **Time of Death:** Unknown

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

County where fatality incident occurred: Oswego
Was 911 or local emergency number called? Yes
Time of Call: 11:11 AM
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	9 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	37 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Other Household 1	Father	No Role	Male	37 Year(s)

LDSS Response

On 05/20/25, OCDSS received the fatality report from the SCR and began their investigation. Within the first 24 hours of the investigation, OCDSS contacted the source of the report, spoke with hospital staff, completed a CPS history check, and coordinated investigative efforts with law enforcement. Law enforcement notified the medical examiner and district attorney's offices of the death.

On 05/20/25, the mother's partner was interviewed. The partner reported that the child had been ill in the days prior to his death. He said that on the day of the death, the child did not feel well and stayed home from school. Around 10:00 AM, the child was fed and then laid down. The mother told the child to get up and he was wobbly. The child did not make sense before he fell to the ground. A call was made to 911 and the child was transported to the hospital via ambulance.

The mother stated that on 05/16/25, she took the child to the doctor for vomiting and that the doctor said the child was fine. The following day, the child said his legs hurt, but they had been walking a lot. On 05/18/25, the child had a decreased appetite but ate at the grandparents' home. On 5/19/25, the child went to school and the nurse reported that the child did not feel well. On the day of the child's death, he did not go to school. The mother checked on the child, and he was on the floor, incoherent. The mother did not know what to do, so she called the child's doctors and then contacted 911.

The pediatrician reported that there were no "red flags" with the mother's care of the child. During an office visit on 05/19/25, the mother said that the child vomited every morning for 3 days. The child could have made himself vomit for attention, had allergies, or an exasperated respiratory condition. The pediatrician noted that the child had severe medical needs due to a preexisting condition. The pediatrician did not have concerns for the care the mother provided to the child nor had concerns regarding the mother's ability to seek medical attention. A nurse reported that there was an "emergency protocol sheet" that the mother was provided with, and which the mother should have provided EMS with.

Medical providers reported that the mother called on the day of the child's death saying the child was "moping around;" however, when called back, the mother and child were in the ambulance. Medical staff reported that the child could "decompensate" quickly due to his condition. The doctor said that the child needed to be seen if he vomited more than twice. The doctor stated the mother historically had not hesitated to call for medical advice.

The paternal grandparents reported seeing the child on 05/18/25. The child did not feel well; however, his temperature was normal. The child ate less than usual and was tired, but they attributed this to having a party the day before. The grandparents did not have concerns for the care the child was provided.

At the time of this writing, the investigation remained open.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical 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?Yes
Comments: The death was referred to an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
072468 - Deceased Child, Male, 9 Year(s)	072469 - Mother, Female, 34 Year(s)	DOA / Fatality	Pending
072468 - Deceased Child, Male, 9 Year(s)	072469 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Pending

072468 - Deceased Child, Male, 9 Year(s)	072469 - Mother, Female, 34 Year(s)	Lack of Medical Care	Pending

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒

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? N/A
Explain:
Due to the sibling's age, service referrals were not made.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The mother and her partner were offered grief counseling referrals, which were accepted. The family accepted burial assistance.

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)
01/15/2025	Deceased Child, Male, 8 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 8 Years	Mother's Partner, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 1 Years	Mother's Partner, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged during the weekend prior to the SCR report, the mother was angry and out of control in the presence of the child. The mother punched the child's TV causing it to fall and break. The child was not injured but was scared. A subsequent SCR report received on 01/20/25 alleged that the mother shoved the child to the ground and slapped his face. It was unknown if the child sustained injuries. The mother's partner pushed the mother to the ground and slapped her in the face in the presence of the child and sibling.

Report Determination: Unfounded | **Date of Determination:** 02/08/2025

Basis for Determination:
The allegations were unsubstantiated. The Investigation Conclusion Narrative reflected there was not evidence to support the allegations. There was no DV. The family was working with a community-based agency and there were no concerns for the children. The child stated that he was "not really" scared when the mother broke the TV.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check was completed timely. A home visit was made, and the family and collateral contacts were interviewed. The RAP was inaccurate. Notice of Existence was provided timely.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP reflected the caretaker had a previous termination of parental rights and noted the child was removed from the care of the mother in 2022; however, this was inaccurate as her rights were not terminated.

Legal Reference:
18 NYCRR 432.2(d)

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/25/2024	Deceased Child, Male, 8 Years	Mother, Female, 34 Years	Choking / Twisting / Shaking	Unsubstantiated	Yes
	Deceased Child, Male, 8 Years	Mother, Female, 34 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged on an unknown date, the mother choked the child. It was unknown if the child was injured.

Report Determination: Unfounded	**Date of Determination:** 02/08/2025

Basis for Determination:
The allegations were unsubstantiated. The Investigation Conclusion Narrative reflected that the child was choked by a cousin. The incident happened over a year prior to the SCR report and there was no further incident. The mother and child confirmed that she did not choke him.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A home visit was made, and the family was interviewed. Collateral contacts were made. The RAP was completed inaccurately. The case was closed with a very high-risk rating. The family received services through a community-based agency. There was a predetermination of safety and risk.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP reflected the caretaker had a previous termination of parental rights and noted the child was removed from the care of the mother in 2022; however, this was inaccurate as her rights were not terminated. The RAP did not reflect the sibling was under 1-year-old.

Legal Reference:
18 NYCRR 432.2(d)

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

Issue:
Pre-Determination/Assessment of Current Safety/Risk

Summary:
The record did not reflect casework activity from 10/16/24 to 01/16/25 and therefore, it remained unknown how safety and risk were assessed.

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

Action:
OCDSS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an on-going assessment of safety and risk throughout the length of the investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/21/2022	Deceased Child, Male, 6 Years	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 6 Years	Father, Male, 35 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 6 Years	Mother, Female, 32 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Deceased Child, Male, 6 Years	Mother, Female, 32 Years	Internal Injuries	Substantiated	

Deceased Child, Male, 6 Years	Mother, Female, 32 Years	Lacerations / Bruises / Welts	Substantiated
Deceased Child, Male, 6 Years	Mother, Female, 32 Years	Lack of Medical Care	Substantiated
Deceased Child, Male, 6 Years	Mother, Female, 32 Years	Lack of Supervision	Substantiated
Deceased Child, Male, 6 Years	Mother, Female, 32 Years	Malnutrition / Failure to Thrive	Substantiated

Report Summary:
An SCR report alleged on 11/20/22, the mother threw a cup at the child for unknown reasons. The child was hit on the hand with a cup and sustained a small laceration to his finger. It was unknown if the mother harmed the child in the past. A subsequent report received on 11/26/22 alleged the child had a genetic disorder that required a dietary treatment plan. The mother was aware the child felt ill with nausea and vomiting yet failed to seek immediate medical attention. As a result, the child was found unresponsive and became hospitalized.

Report Determination: Indicated	**Date of Determination:** 12/28/2022

Basis for Determination:
The Investigation Conclusion Narrative noted that the SM failed to seek medical care for the SC in a timely manner. The SC suffered a brain injury as a result. The SM did not adequately care for the SC's medical needs present since birth. IF/C/S and MITT were added to the investigation as the SM knew how to feed the SC yet failed to do so, causing the SC to have "dangerously low" blood sugar levels, resulting in negative neurological events. LS was added and substantiated as the SM left the SC with an inappropriate caregiver. IG was added and substantiated against the BF noting he was incarcerated due to sexually abusing a minor; however, the record did not reflect how the SC was impacted.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The family and collaterals were interviewed. A CPS history check was completed timely. An Article 10 Neglect Petition was filed, and the child began residing with the PS's aunt. The RAP was inaccurate. The child was then placed in the care of the maternal aunt. The case was indicated and opened for Services as the child was in Foster Care.

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

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP reflected the father was a secondary caretaker; however, the record noted that he was incarcerated and did not have caretaking responsibilities.

Legal Reference:

18 NYCRR 432.2(d)

Action:

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/25/2022	Deceased Child, Male, 6 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	No

Deceased Child, Male, 6 Years	Mother, Female, 31 Years	Lack of Medical Care	Unsubstantiated
Deceased Child, Male, 6 Years	Mother, Female, 31 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Deceased Child, Male, 6 Years	Father, Male, 34 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 6 Years	Father, Male, 34 Years	Lack of Medical Care	Unsubstantiated
Deceased Child, Male, 6 Years	Father, Male, 34 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged the SC had a gastric button for feedings. The skin around the button was deteriorating, swollen and "oozing." The parents were aware that the SC needed medical care yet failed to provide it. The SC was supposed to be fed via the button every 6 hours. The father refused to feed the SC. The mother did not want to feed the SC appropriately, so she doubled the amount when he was fed. The SC was able to eat some solid food, but the adults refused to allow him to do so. The adults consumed alcohol to the point of intoxication and were unable to care for the SC. The adults had MH concerns that were untreated, causing them to be incapable of caring for the SC.

Report Determination: Unfounded

Date of Determination: 10/15/2022

Basis for Determination:
The allegations were unsubstantiated. The Investigation Conclusion Narrative reflected there was not a fair preponderance of evidence to support the allegations. The adults did not excessively drink alcohol. The adults were able to appropriately provide medical care to the child and feed him appropriately.

OCFS Review Results:
The investigation was initiated timely. The Safety Assessments were completed timely and with accuracy. The RAP was completed accurately. Home visits were made, the family was interviewed, and appropriate collateral contacts were made.

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

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

07/31/17-09/07/17 A case tracked FAR included a concern for IG regarding the father and child.

02/25/20-04/20/20 IG and PD/AM were substantiated against the father regarding the child.

09/04/20-11/04/20 IG was unsubstantiated against the parents regarding the child.

10/31/20-12/02/20 IG was unsubstantiated against the parents regarding the child.

01/20/21-04/21/21 IG was substantiated against the parents regarding the child.

12/17/21-07/07/22 IG and L/B/W were unsubstantiated against the mother regarding the child and another child.

04/06/22-07/07/22 The mother and her partner were unsubstantiated for IG, IF/C/S, LMC and PD/AM regarding the child. The mother's partner was unsubstantiated for SA regarding the child.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Preventive Services History

On 11/28/22, a Services case was opened as the mother and father failed to appropriately tend to and seek medical treatment for the child's needs. As a result, the child was found unresponsive on 11/25/22. The child was then removed from the mother's care and placed with the maternal aunt. At that time, the case was transferred to Foster Care and specifics will be noted within that section. The child was discharged to the mother on 11/30/23. OCDSS continued to monitor the mother and child under a court order that expired in April 2024. The case was closed on 04/10/24.

Foster Care Placement History

On 11/28/22, a Services case was opened as the mother and father failed to appropriately tend to and seek medical treatment for the child's needs. As a result, the child was found unresponsive on 11/25/22. He was transported to the hospital via EMS and was admitted for medical treatment. As a result of the parents' neglect, an Article 10 Neglect Petition was filed on 11/30/22. The mother consented to the removal of the child, and he was placed with a maternal aunt. The family was provided with mental health services, respite care, public health nursing, parenting training and case management services. An order of protection was granted on behalf of the child and against the mother. The mother was granted court-ordered supervised visits. The father was incarcerated for crimes unrelated to the child's care. The mother was cooperative with the court orders and met all service plan goals. On 06/07/23, the child was placed on a trial discharge to the mother's care. The mother was able to adequately care for the child and meet his needs. The child was discharged from Foster Care on 10/30/23. OCDSS continued to monitor the mother and child under a court order that expired in April 2024. The case was closed on 04/10/24.

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:**
11/30/2022	Adjudicated Neglected	Order of Supervision
Respondent:	Father Male 37 Year(s), Mother Female 34 Year(s)	
Comments:	As a result of the Article 10 Neglect Petition, and the removal of the child, there was a finding of Neglect against the parents. An order of supervision was granted on behalf of the child, and the parents met all requirements of the court order.	

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