Child Fatality Report

Report Identification Number: RO-25-009

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

Issue Date: Jun 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 Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	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-Case Worker	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: 6 month(s)
Jurisdiction: Ontario
Gender: Male
Date of Death: 03/10/2025
Initial Date OCFS Notified: 03/10/2025

Presenting Information

An SCR report was received on 3/10/25, which stated at an unknown time, the 6-month-old child was placed on a Boppy pillow in a playroom where he fell asleep for an unknown amount of time. The father was left in charge of caring for the child while the mother took a nap with the two-year-old sibling. During that time, the father went outside to do yard work, leaving the child without supervision for an unknown amount of time. When the mother awoke at approximately 1:40pm, she found the child on the Boppy pillow, unconscious and not breathing. The mother called 911, EMS arrived at the home and began CPR, but they were unable to revive the child. The child was pronounced deceased at the home due to an unsafe sleep situation.

Executive Summary

This report concerns the death of a 6-month-old male child. Ontario County Department of Social Services (OCDSS) received an SCR report regarding the child's death on 3/10/25. At the time of the child's death, he resided with his mother, father and two siblings, ages 2 and 3.

According to the family, at approximately 10:30am, the subject mother placed the subject child on a Boppy pillow in his playroom and went to take a nap in her bedroom. The subject father reported he checked on the child at 11:00am and observed him to be alert and content. At 1:36pm, the subject mother awoke and observed him to be cold, stiff and unresponsive. EMS and law enforcement responded to the home but were unable to resuscitate the child and he was pronounced deceased.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation was closed. Law enforcement responded to the scene of the fatality but did not pursue criminal charges in relation to the death.

The allegations of inadequate guardianship, lack of supervision and lack of medical care against both parents for the subject child and his surviving siblings, were substantiated. The investigation revealed the subject child was left without appropriate supervision for several hours during the incident. It was also discovered that the subject child and his siblings, were significantly behind on their medical appointments and the medically fragile sibling was not receiving the required specialized services needed for his medical disabilities.

The allegations of inadequate guardianship, lack of supervision and lack of medical care against the maternal grandmother for the subject child and his surviving siblings, were substantiated. It was revealed through the investigation that the maternal grandmother had a caregiver role for all of the children and was the primary caregiver of the 3-year-old, medically fragile sibling. It was also discovered that the maternal grandmother had cancelled many of the children's medical and therapeutic appointments. She also stated during the investigation that she did not feel the therapeutic services were necessary or beneficial and she could do more by just reading a book.

The allegation of DOA/Fatality against the subject mother and subject father was appropriately unsubstantiated. The fatality of the child appeared unintentional, and the parents appropriately contacted emergency services when they discovered he was in distress.

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:

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

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

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

Explain:

A Family Services Stage was opened for long-term monitoring and services of the family.

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: 03/10/2025 **Time of Death:** 01:51 PM

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

County where fatality incident occurred: Ontario
Was 911 or local emergency number called? Yes
Time of Call: 01:36 PM
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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	56 Year(s)

LDSS Response

On 3/10/25, an SCR report was received regarding the death of a 6-month-old subject child. OCDSS initiated their investigation immediately, notified the district attorney, communicated with the medical examiner and EMS, coordinated with law enforcement, completed a CPS history review and conducted a thorough home visit.

The subject mother was interviewed and stated she fed the subject child via his feeding tube from 9:00-10:00am. She stated she then flushed the tube with water for thirty minutes and placed the child on a Boppy pillow, in the playroom. She then informed the subject father she was going to take a nap in her bedroom with the 2-year-old sibling. At 1:36pm, she awoke and observed the child to be cold, stiff and unresponsive on the Boppy pillow. She stated his airway was not obstructed but his head was leaned back. The maternal grandmother and subject father heard her screaming and ran in to assist. They moved the child to the living room and contacted 911. Law enforcement and EMS responded but were unable to resuscitate him. He was pronounced deceased at 1:51pm.

The subject father stated he was outside doing yard work during the incident. He stated he checked on the child at approximately 11:00am and observed him to be alert and content on the Boppy pillow in the playroom.

OCDSS interviewed the maternal grandmother who resided next door. She stated she is the primary caregiver for the 3-year-old surviving sibling, due to his medical concerns. She stated he was hospitalized for the first year of his life due to a birth defect. She stated he has a feeding tube and has had multiple surgeries. During the interview, the sibling began to vomit and appeared to have a seizure. The parents and MGM did not seem concerned, and MGM stated he was probably just over stimulated. OCDSS instructed the family to call 911 and have him evaluated. The MGM called 911 and accompanied him to the hospital via ambulance. The parents did not say goodbye to the sibling or accompany him to the ambulance. The sibling was diagnosed with a viral infection and was released from the hospital a few days later.

OCDSS made collateral contacts with the subject child and the surviving sibling's medical providers and reviewed their extensive medical records. It was quickly discovered that the subject child and the 3-year-old sibling required specialized services and medical care that they were not receiving. They also discovered that both the subject mother and the MGM had repeatedly canceled their medical appointments. The family also refused recommended genetic testing, early intervention services and home health care services for the children.

On 3/11/25, the surviving siblings were removed from their parent's care and custody and placed in the relative foster home of their paternal grandfather. A neglect petition was filed in family court the following day and the parents were granted supervised contact with the children.

During the investigation, OCDSS assisted with burial planning and offered grief counseling referrals, which the family declined. OCDSS also made early intervention referrals and assisted with rescheduling ten medical appointments for the medically fragile sibling that had been missed.

At the time the investigation was closed, a Family Services Stage case was open for ongoing support and services of the family.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Pending

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

Comments: The fatality was referred to the Ontario/Seneca/Yates Child Fatality Review team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
071043 - Deceased Child, Male, 6 Month(s)	071044 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated

071043 - Deceased Child, Male, 6 Month(s)	071048 - Grandparent, Female, 56 Year(s)	Lack of Supervision	Substantiated
071043 - Deceased Child, Male, 6 Month(s)	071048 - Grandparent, Female, 56 Year(s)	Lack of Medical Care	Substantiated
071043 - Deceased Child, Male, 6 Month(s)	071048 - Grandparent, Female, 56 Year(s)	Inadequate Guardianship	Substantiated
071043 - Deceased Child, Male, 6 Month(s)	071045 - Father, Male, 26 Year(s)	Lack of Supervision	Substantiated
071043 - Deceased Child, Male, 6 Month(s)	071045 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
071043 - Deceased Child, Male, 6 Month(s)	071044 - Mother, Female, 24 Year(s)	Lack of Supervision	Substantiated
071043 - Deceased Child, Male, 6 Month(s)	071045 - Father, Male, 26 Year(s)	Lack of Medical Care	Substantiated
071043 - Deceased Child, Male, 6 Month(s)	071045 - Father, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated
071043 - Deceased Child, Male, 6 Month(s)	071044 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated
071043 - Deceased Child, Male, 6 Month(s)	071044 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
071046 - Sibling, Male, 3 Year(s)	071044 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated
071046 - Sibling, Male, 3 Year(s)	071048 - Grandparent, Female, 56 Year(s)	Lack of Medical Care	Substantiated
071046 - Sibling, Male, 3 Year(s)	071048 - Grandparent, Female, 56 Year(s)	Inadequate Guardianship	Substantiated
071046 - Sibling, Male, 3 Year(s)	071044 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
071046 - Sibling, Male, 3 Year(s)	071045 - Father, Male, 26 Year(s)	Lack of Supervision	Substantiated
071046 - Sibling, Male, 3 Year(s)	071048 - Grandparent, Female, 56 Year(s)	Lack of Supervision	Substantiated
071046 - Sibling, Male, 3 Year(s)	071045 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
071046 - Sibling, Male, 3 Year(s)	071044 - Mother, Female, 24 Year(s)	Lack of Supervision	Substantiated
071046 - Sibling, Male, 3 Year(s)	071045 - Father, Male, 26 Year(s)	Lack of Medical Care	Substantiated
071047 - Sibling, Female, 2 Year(s)	071045 - Father, Male, 26 Year(s)	Lack of Medical Care	Substantiated
071047 - Sibling, Female, 2 Year(s)	071044 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
071047 - Sibling, Female, 2 Year(s)	071044 - Mother, Female, 24 Year(s)	Lack of Medical Care	Substantiated
071047 - Sibling, Female, 2 Year(s)	071045 - Father, Male, 26 Year(s)	Lack of Supervision	Substantiated
071047 - Sibling, Female, 2 Year(s)	071045 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated

071047 - Sibling, Female, 2 Year(s)	071048 - Grandparent, Female, 56 Year(s)	Inadequate Guardianship	Substantiated
071047 - Sibling, Female, 2 Year(s)	071044 - Mother, Female, 24 Year(s)	Lack of Supervision	Substantiated
071047 - Sibling, Female, 2 Year(s)	071048 - Grandparent, Female, 56 Year(s)	Lack of Medical Care	Substantiated
071047 - Sibling, Female, 2 Year(s)	071048 - Grandparent, Female, 56 Year(s)	Lack of Supervision	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐

Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The siblings were placed in the kinship foster home of their paternal grandfather. The Department assisted with rescheduling all of the siblings missed medical appointments and therapy services. Referrals were made with contract agencies for home health care and supervised visitation. An FSS was opened for long-term services of the family.

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:
A protective removal of the surviving siblings was conducted on 3/11/25. An Article 10 neglect petition was filed in Family Court on 3/12/25. The children were placed in the kinship foster home of their paternal grandfather.

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:**
03/12/2025	There was not a fact finding	There was not a disposition
Respondent:	071044 Mother Female 24 Year(s)	
Comments:		

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/12/2025	There was not a fact finding	There was not a disposition
Respondent:	071045 Father Male 26 Year(s)	
Comments:		

Have any Orders of Protection been issued? Yes	
From: 03/12/2025	**To:** Unknown

Explain:
An article 10 Neglect Petition was filed against the subject mother and subject father on 3/12/25, and OCDSS requested the remand of the siblings. The Judge approved the remand and the siblings were placed in kinship foster care with their PGF. The subject mother and subject father were granted supervised contact.

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

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
Bereavement counseling	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒
Funeral arrangements	☒	☐	☐	☐	☐	☐

Housing assistance	☐	☐	☐	☐	☐	☒
Mental health services	☐	☒	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☒
Legal services	☐	☐	☐	☐	☐	☒
Family planning	☐	☐	☐	☐	☐	☒
Homemaking Services	☐	☐	☐	☐	☐	☒
Parenting Skills	☐	☐	☐	☒	☐	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒
Early Intervention	☒	☐	☐	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒
Child Care	☐	☐	☐	☐	☐	☒
Intensive case management	☒	☐	☐	☐	☐	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐
Preventive Services	☒	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes

Explain:

The 3-year-old sibling was medically fragile and not receiving the specialized services he required. Services were reinstated for him following his placement into foster care. Early intervention services were began for the 2-year-old sibling following her placement into foster care.

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:

Grief counseling and mental health counseling was offered to the family, but they declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No

Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/12/2023	Sibling, Male, 1 Years	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 1 Years	Mother, Female, 23 Years	Lack of Medical Care	Substantiated	
	Sibling, Male, 1 Years	Mother, Female, 23 Years	Malnutrition / Failure to Thrive	Substantiated	
	Sibling, Female, 5 Months	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 5 Months	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 5 Months	Mother, Female, 23 Years	Lack of Medical Care	Substantiated	
	Sibling, Female, 5 Months	Mother, Female, 23 Years	Malnutrition / Failure to Thrive	Substantiated	
	Sibling, Male, 1 Years	Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Male, 1 Years	Father, Male, 25 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 1 Years	Father, Male, 25 Years	Lack of Medical Care	Substantiated	
	Sibling, Male, 1 Years	Father, Male, 25 Years	Malnutrition / Failure to Thrive	Substantiated	
	Sibling, Female, 5 Months	Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Sibling, Female, 5 Months	Father, Male, 25 Years	Inadequate Guardianship	Substantiated	

Sibling, Female, 5 Months	Father, Male, 25 Years	Lack of Medical Care	Substantiated
Sibling, Female, 5 Months	Father, Male, 25 Years	Malnutrition / Failure to Thrive	Substantiated
Sibling, Male, 1 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Substantiated

Report Summary:
An SCR report received on 4/12/23 stated that the 5-month-old child was born weighing 10 lbs,10 oz. Since birth she had lost weight. The mother was breastfeeding and refused to supplement with formula. A referral was made to a specialist and for the child to have blood work, but the parents failed to comply. The 1-year-old sibling was born with many health complications. He stayed in the hospital for the first year of his life and had many surgeries. He had an oral aversion to food and could only eat through a feeding tube. The parents were not following the feeding plan and were trying to feed him orally. As a result he had lost height and weight since coming home from the hospital.

Report Determination: Indicated | **Date of Determination:** 06/07/2023

Basis for Determination:
There was a fair preponderance of the evidence to support the allegations of IF/C/S, IG, M/FTTH and LMC of the surviving siblings by the SM and SF. The 1-year-old child spent the first year of his life at the hospital due to his premature birth and medical conditions and had lost weight since coming home. He was scheduled to have a surgery but due to his weight loss, the surgeons refused to operate. There were multiple missed medical appointments. Visiting nurses were in the home weekly and observed many times the child had not had his feeding tube in. A neglect petition was filed.

OCFS Review Results:
The investigation was initiated timely, and a home visit was conducted promptly. Collateral contacts were made for the children with their medical providers and visiting nurses. Safe sleep was discussed. An Article 10 neglect petition was appropriately filed. An FSS case was opened for long term monitoring and services.

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)
12/28/2022	Sibling, Male, 1 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 1 Years	Father, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received on 12/28/22 stated that the 11-month-old child was born with multiple medical issues and had been hospitalized since birth. The child was medically ready for discharge, but the mother and father did not follow through with the necessary training needed to care for the child. The child had a feeding tube which required the parents to learn how to mix the formula, administer medication through the tube and how to flush it. The child also required oxygen, and the parents needed to learn how to recognize signs of respiratory distress in the child. As a result of the parent's lack of follow through with the training, it was not safe to discharge the child.

Report Determination: Unfounded | **Date of Determination:** 02/01/2025

Basis for Determination:
Allegations from the report dated 12/28/22 of IG of the surviving sibling, by the subject father and subject mother, were unfounded. The parents completed the necessary training that was required for the child to be discharged from the

hospital, within the scheduled time frame set by the hospital. The parents showed no signs of inadequacy in caring for the child or meeting his medical needs. The parents attended the child's medical appointments as scheduled. The parents had several family supports and were also utilizing a nursing service that came to the home weekly.

OCFS Review Results:
The investigation was initiated timely, the source was contacted, and a CPS history review was completed. Safety assessments and the RAP were completed timely and accurately. Collateral contacts were made for the child, and no concerns were documented. Safe sleep practices were discussed.

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

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

No known CPS history outside of NYS.

Preventive Services History

6/7/23-10/3/24. Court ordered Family Support Services case to monitor the health and development of the children. The case was closed at the parent's request when their Family Court orders expired. At the time the case was closed, the children had appropriately gained weight, were up to date medically and had no safety concerns.

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