Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-22-016

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

Issue Date: Oct 28, 2022 **(Report was reissued on: Oct 31, 2022)**

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 has an open 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: 7 year(s)
Jurisdiction: Saratoga
Gender: Male
Date of Death: 05/03/2022
Initial Date OCFS Notified: 05/03/2022

Presenting Information

An SCR report was received which alleged that on 5/3/22, the subject father found the seven-year-old subject child unresponsive in the home at 8:30AM. The father called 911 for emergency medical treatment, and the child was transported via ambulance to the hospital. The child was pronounced deceased at the hospital at 8:56AM. The father had no explanation for the subject child's death.

Executive Summary

This fatality report concerns the death of a seven-year-old male subject child that occurred on 5/3/22. A report was registered with the SCR on that same date with allegations of Inadequate Guardianship and DOA/Fatality against the child's father. Saratoga County Department of Social Services (SCDSS) received the report and investigated the child's death. An autopsy was completed, and the official cause of death was "respiratory failure due to severe chronic interstitial pneumonia due to severe lissencephaly, cerebral malformations, and spastic quadriparesis since birth." The manner of death was natural.

At the time of the child's death, he resided with his father and two surviving siblings, both seven years old; one of the siblings was the subject child's twin. The mother lived in another state and had minimal contact with the children. The investigation revealed that the subject child suffered from numerous severe medical conditions since birth, was considered medically fragile, and needed a high level of care. The child was fed and given medication via gastrointestinal tubes, was blind, nonverbal, and immobile. He saw his pediatrician, specialists, and in-home health aides regularly. The child's father also lived with medical conditions that effected his ability to walk, and he utilized a wheelchair; however, it was found this did not hinder his ability to meet the subject child's needs. On 5/2/22, it was reported that the subject child had been experiencing a respiratory virus as well as vomiting and diarrhea for several days. It was noted that these symptoms were not unusual given the subject child's conditions. Throughout the night, the subject child was cared for by his father and the overnight nursing aide. The child was given medications, his diaper was changed, and was last seen alive by the father at 6:30AM on 5/3/22. At approximately 8:00AM, the father went to tend to the child's needs and found him unresponsive on the couch. The father immediately called emergency services, and the child was brought to the hospital via ambulance where he was pronounced deceased at 8:56AM.

SCDSS spoke with several collateral sources, including law enforcement, the medical examiner, first responders, medical providers, and hospital staff. There were no concerns that the subject child's death was a result of abuse or maltreatment of any kind. There were no criminal charges brought against the father regarding the fatality, and the surviving siblings were assessed on numerous occasions and deemed safe in the father's care. SCDSS noted there was no evidence to support what was alleged in the report, and therefore the allegations against the father were unsubstantiated. The father agreed to voluntary preventive services to continue to assist the family with their ongoing needs due to the father's declining health. The case remained open at the time this report was issued.

PIP Requirement

This review resulted in citations related to casework practice. In response, SCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the SCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, SCDSS will review the plan(s) and revise as needed.

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:
SCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving siblings.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the 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: 05/03/2022 **Time of Death:** 08:56 AM

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

County where fatality incident occurred: Saratoga
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 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	7 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	62 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Other Household 1	Mother	No Role	Female	31 Year(s)

LDSS Response

On 5/3/22, SCDSS received the SCR fatality report regarding the death of SC. At the time of fatality, the family was involved in 2 ongoing CPS investigations with concerns surrounding SF's ability to appropriately care for the CHN due to having his own health issues.

On 5/4/22, SCDSS and LE visited the family's residence. The SSs were observed and deemed safe. SF was unable to be fully interviewed due to his emotional state. On this same date, SCDSS spoke with BM via phone as she lived out of state. BM explained she last saw the CHN in November 2021, and last spoke to them in January 2022. She reported SF stopped taking her calls for reasons she did not know. BM had no information regarding SC's death.

SCDSS made several attempts to interview SF surrounding the fatality report allegations, but SF stated he could not emotionally handle talking about the incident. Due to this, SCDSS learned a timeline of events from LE and SC's overnight nursing aide (NA). NA reported SC had been ill the past few days with some vomiting and diarrhea; however, this was not unusual given SC's conditions. She explained she cared for SC overnight from 5/2/22 to 5/3/22. NA stated SC was sleeping when she arrived at the home, which was normal, and she and SF tended to SC throughout the night. She stated at around 3:00AM, SC made a "grunting sound," and SF told her he did that when he had to go to the bathroom. NA stated they checked on him, and his stomach felt hard. NA reported SF gave SC his medications, he had a bowel movement, and then they changed him and cleaned him. She stated SC was asleep during all of this, and she last checked on him before she left at 6:00AM; he was still asleep. LE informed SCDSS that SF checked on SC around 6:30AM and he was fine. LE stated that around 8:00AM is when SF found SC unresponsive, and he immediately called 911.

On 5/4/22, SCDSS spoke with SC's pediatrician. The Dr. explained he last saw SC on 3/29/22 for a routine exam, which occurred every 6 weeks. He stated SC "was in his usual state of health," and was finishing antibiotics for a cough that was nearly resolved at the time of that appointment. The Dr. stated SC saw numerous specialists for his health conditions. It was explained that SF had been trying to get around-the-clock care in the home for SC, but the insurance company kept giving him pushback. An overnight nurse was approved on 4/29/22 for 48 hours per week. The Dr. reported SF knew how to take care of SC and he had no concerns surrounding this.

On 5/9/22, SCDSS observed LE interview the SSs at the CAC. Both SS explained they assisted with SC's care daily by administering breathing treatments and food into SC's medical tubes in the mornings and evenings. The SSs stated SF taught them how to do this, and he was usually not present. The SSs said they did not take part in cleaning SC or giving him any medications. Neither SS disclosed any safety concerns nor concerns regarding SF's care of SC. They had no additional information surrounding SC's death. The record did not reflect if SCDSS explored the expectation that the SSs administer such care to the SC, considering their age and development, with SF or SC's medical providers.

SCDSS spoke with numerous collateral sources, and those involved in SC's regular care and treatment disclosed no concerns surrounding SF or his ability to appropriately care for SC. School staff reported SF was very involved and responsive, described SC as "very medically fragile," and that they had no CPS concerns. LE stated their investigation did not reveal any signs of abuse or neglect, and there would be no criminal charges filed. SCDSS did not find evidence that SF's actions or inaction led to the death of SC, and unsubstantiated the allegations. SF agreed to voluntary preventive services due to his own declining health, and that case remained ongoing at the time of this writing.

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
Comments: This fatality investigation was conducted by the Saratoga County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: Saratoga County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061755 - Deceased Child, Male, 7 Yrs	061758 - Father, Male, 62 Year(s)	DOA / Fatality	Unsubstantiated
061755 - Deceased Child, Male, 7 Yrs	061758 - Father, Male, 62 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?	☒	☐	☐	☐
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?	☒	☐	☐	☐

Additional information:
SCDSS interviewed the family and appropriate collateral sources. The mother lived out of state and was interviewed via phone. Progress notes and other documentation were completed and entered timely.

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: SCDSS offered the family appropriate services in response to the SC's death.				

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The surviving siblings did not need to be removed as a result of this fatality report.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
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	☐	☐	☐	☐	☐	☒	☐
Other	☒	☐	☐	☐	☐	☐	☐
Other, specify: Voluntary Preventive Services							
Additional information, if necessary: SCDSS provided the family with grief and bereavement counseling referrals. A services case was opened following the fatality to continue to assist the father with caring for the siblings due to his declining health.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
SCDSS provided referrals for grief and bereavement counseling for the siblings following the fatality. The siblings were engaged in services through their school, and a preventive services case was opened after the subject child's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SCDSS provided the parents and other caretakers referrals for grief and bereavement counseling following the fatality. The father had numerous service providers assisting him with his medical needs, and a preventive services case was opened after the subject child's death.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
Were there any siblings ever placed outside of the home prior to this child's death? 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)

04/14/2022	Deceased Child, Male, 7 Years	Father, Male, 62 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 7 Years	Father, Male, 62 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that SC's medical conditions resulted in problems with movement and developmental delays, and he depended on SF to meet all his needs. SF also had medical conditions and was very weak. As a result, SF was failing to adequately supervise SC, and SC sustained multiple unexplained bruises over the past two months. SC also had open blisters on his left leg believed to be from bed sores. SC's wheelchair was recently replaced, and SF adjusted the seat to where SC no longer had head control or support. The SSs had unknown roles.

Report Determination: Unfounded | **Date of Determination:** 06/30/2022

Basis for Determination:
SCDSS interviewed family and collaterals. SF denied the allegations and SC was observed to be free from visible marks and bruises. SCDSS noted SC's wheelchair head rest appeared to appropriately support his head. SC died during this investigation. Medical contacts made after his death noted no concerns regarding SC or his care. SC's providers noted SC could be home alone for up to 45 minutes if he was in his wheelchair. It was determined bed sores were normal for someone with SC's lack of mobility, and medical notes did not report any concerning sores or bruising. SCDSS unfounded and closed the case.

OCFS Review Results:
A fair preponderance of evidence was not found to support the allegations in the report. This investigation met all statutory requirements.

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)
04/09/2022	Deceased Child, Male, 7 Years	Father, Male, 62 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 7 Years	Father, Male, 62 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 7 Years	Other - Health Aide, Female, 36 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 7 Years	Father, Male, 62 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 62 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Other - Health Aide, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Other - Health Aide, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that SF was wheelchair bound and unable to control the SSs. The babysitter was also unable to control the SSs. The SSs set at least 4 fires over the past month while SC and SF were in the home; SC was also wheelchair bound. There were concerns SC would not be able to exit the home in case of a fire.

Report Determination: Unfounded | **Date of Determination:** 06/30/2022

Basis for Determination:
SCDSS spoke with SF, the babysitter, and collateral sources. SF reported the SSs were lighting holes in his clothing, but

would not admit it, so he had the babysitter bring them to the fire station to learn about fire safety and the danger of setting fires. SCDSS confirmed this with the fire station staff and the babysitter. SF reported he had since secured all of his lighters so the SSs could not get to them. The CHN were observed to be free from marks and bruises and deemed safe. SC died while this investigation was open. The case was unfounded and closed.

OCFS Review Results:
Although the SSs were interviewed, the record did not reflect if the allegations regarding fire setting were explored. It remained unknown what the SSs had used to light SF's clothing on fire, or if they were aware of what to do in case of a fire emergency.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
Although the SSs were brought to the fire station for education regarding fire setting, the record did not reflect SCDSS interviewed the SSs regarding the allegations pertaining to them having lit at least 4 fires over the past month.

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

Action:
Prior to making a determination of a report of abuse and/or maltreatment, the investigation conducted by the child protective service shall include a determination of the nature, extent and cause of any condition enumerated in the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/26/2022	Deceased Child, Male, 7 Years	Father, Male, 62 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 7 Years	Father, Male, 62 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 7 Years	Father, Male, 62 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Father, Male, 62 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 62 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 62 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that on at least 3 occasions, SF left the CHN without adequate supervision. On 1/26/22, SF left SC and the twin SS home alone, and SF was aware SC was a medically fragile, wheelchair bound, had seizures, and required adult supervision.

Report Determination: Unfounded | **Date of Determination:** 03/30/2022

Basis for Determination:
SCDSS spoke with the family and collateral sources. SF denied the allegations and explained that on 1/26/22 he and the youngest SS went to take the trash out, which required walking through the apartment complex to the dumpster. SF stated that was the only time the CHN were unsupervised. SCDSS confirmed this with LE, as the source of the report contacted LE for a welfare check. The SSs were interviewed and denied being left home alone as well as any safety concerns. SC could not be interviewed but appeared well cared for. SC's medical providers reported no concerns. The allegations against were unfounded and the investigation was closed.

OCFS Review Results:
This investigation met all statutory requirements.

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)
09/10/2021	Deceased Child, Male, 7 Years	Father, Male, 61 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
This SCR report was received with concerns SF was failing to adequately care for SC, who had special needs. SC was found to have dried feces on the bottom of his foot and in-between his toes. He also had red, irritated, and splitting skin on his neck and groin.

Report Determination: Unfounded **Date of Determination:** 10/25/2021

Basis for Determination:
SCDSS spoke with the family and collateral sources. SF denied the allegations and reported SC had a bowel movement right before his bus came for school, and he was in a hurry cleaning him. He explained he may have missed a spot on his foot. SF said the irritated skin is ongoing and the Dr. is aware; ointments are prescribed and administered by SF and the school nurse. SCDSS observed the irritated skin and noted it did not look painful or infected. The SSs disclosed no concerns, nor did SC's medical providers or in-home nurse. The case was unfounded and closed.

OCFS Review Results:
This investigation met all statutory requirements.

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)
05/19/2021	Deceased Child, Male, 6 Years	Father, Male, 61 Years	Lack of Medical Care	Unsubstantiated	Yes
	Deceased Child, Male, 6 Years	Father, Male, 61 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 61 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 61 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 61 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 61 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 61 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 61 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
This SCR report was received with concerns SF had severe medical conditions that diminished his ability to provide SC with the level of care needed. SC was a medically fragile child. On the morning of 5/19/21, SC was in his wheelchair and covered from head to toe in "regurgitated bile." SC was excessively vomiting through the night, but SF never cleaned SC or sought medical care. SF would leave the CHN in the home without supervision. On 4/28/22, SF left the CHN alone from 9:00AM to 11:00AM while he went to the store. SF was aggressive toward the SSs, and both had suspicious bruises on their buttocks in the past. At that time, SF was heard throwing the SSs back and forth.

Report Determination: Unfounded	**Date of Determination:** 07/09/2021

Basis for Determination:
SCDSS spoke with family and collateral sources. SF denied the allegations, including SC being covered in regurgitated bile on 5/19/21, and reported SC would vomit due to his medical issues. LE reported a welfare check where someone claimed the CHN were home alone but LE found SF home with the CHN. The SSs were interviewed and denied having bruises, safety concerns or being left alone. SC's doctors were spoken with and denied concerns regarding SC's care. SF had friends assisting with the CHN and a care manager for SC. SF was in the process of finding services through his insurance for in-home care for himself. SF declined services through SCDSS. SCDSS unfounded and closed the investigation.

OCFS Review Results:
It was noted that BM had photos of SC covered in vomit and she was willing to share those photos with SCDSS; however, the record did not reflect if SCDSS followed up with the mother to view or obtain the photos prior to determining the allegations.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
The mother reported to SCDSS that she had photos of the subject child covered in vomit, and SC's medical provider requested those photos in order to provide feedback regarding the allegations in the report; however, the record did not reflect any additional follow up with the mother to obtain the photos or view them.

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

Action:
SCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/23/2020	Deceased Child, Male, 6 Years	Father, Male, 61 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 6 Years	Father, Male, 61 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Father, Male, 61 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 6 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 30 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 6 Years	Mother's Partner, Male, 56 Years	Inadequate Guardianship	Unsubstantiated	

Deceased Child, Male, 6 Years	Mother's Partner, Male, 56 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 6 Years	Mother's Partner, Male, 56 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 6 Years	Mother's Partner, Male, 56 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 5 Years	Mother's Partner, Male, 56 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 5 Years	Mother's Partner, Male, 56 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
This SCR report was received by Washington County Department of Social Services (WCDSS) with concerns that on 11/22/20, around 6:00PM, SF got into a verbal altercation with BM's boyfriend (OA) in the presence of the CHN. During the altercation, SF intentionally bumped into OA's shoulder, then picked up a knife in a threatening manner. The CHN were not injured. A SUB report was received on 12/21/20 with concerns that over the previous weekend, BM and OA were misusing drugs while BM's 5 CHN were present, and the youngest SS brandished a knife at OA.

Report Determination: Unfounded | **Date of Determination:** 01/19/2021

Basis for Determination:
The SSs were interviewed, and the younger SS had no knowledge of an argument. The twin SS reported hearing SF, BM and OA arguing, but denied witnessing anything. Neither SS reported any safety concerns. SF, BM, and OA reported the argument stemmed from BM not returning the CHN's clothes after visits. SF denied threatening OA with a knife. SF said he pointed a knife upward during the argument. SF was issued an appearance ticket by LE. All adults reported the CHN were not at BM's home over the weekend, and BM's rights were terminated for her other CHN. Both she and OA denied misusing drugs. WCDSS unsubstantiated the allegations and referred the family to community-based services.

OCFS Review Results:
This investigation met all statutory requirements.

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)
09/09/2019	Sibling, Male, 5 Years	Father, Male, 59 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 4 Years	Father, Male, 59 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received by Washington County Department of Social Services (WCDSS) with concerns that on two separate occasions, SF left gas on for the stove for an extended period while the SSs were present in the home. On 9/9/19, the smell of gas was so strong that the entire apartment building had to be evacuated and the fire department was called. It was unknown if the SSs had sustained any injuries because of the incident.

Report Determination: Unfounded | **Date of Determination:** 11/29/2019

Basis for Determination:
WCDSS interviewed SF, the SSs and collateral sources. SF reported 2 incidents: One was 4-6 weeks prior, when he was home alone and forgot to turn the stove off after cooking. He smelled the gas himself and turned off the stove. The second incident was on 9/9/19, when he was walking through the kitchen and bumped into one of the stove knobs. He stated the FD showed up because a neighbor smelled gas. The SSs were asleep at that time and were unharmed. SF purchased knob covers for the stove. The FD confirmed the incident. SC was discharged home from a nursing facility on 10/21/19. Aides were in the home 60 hours per week to help with his care. WCDSS found no negative impact to the SSs.

OCFS Review Results:
This investigation met all statutory requirements.

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)
05/16/2019	Sibling, Male, 4 Years	Father, Male, 59 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 4 Years	Father, Male, 59 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 3 Years	Father, Male, 59 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Father, Male, 59 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
This SCR report was received by Washington County Department of Social Services (WCDSS) with concerns that on 5/15/19, the then 4yo SSs were riding bikes without helmets and SF was not properly supervising them. As a result, the twin SS rode into the road and was almost hit by a car.

Report Determination: Unfounded **Date of Determination:** 07/19/2019

Basis for Determination:
The SSs were in foster care during this INV, and SC was in a nursing facility as SF had recently had a medical emergency that required surgery. SF signed voluntary placement for the CHN and was allowed 3 hours of unsupervised visits weekly. The SSs reported they do not have bike helmets at SF's house, and the twin SS accidentally went into the road. SF was supervising and yelled to get away from the road, but was unable to run after the SS. WCDSS found SF was still learning new limitations post-surgery and would no longer allow the SSs to ride their bikes unless in an enclosed area. SCDSS provided SF with helmets. The allegations were unsubstantiated as the incident had no negative impact.

OCFS Review Results:
This investigation met all statutory requirements.

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

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

The subject child and surviving siblings were named as alleged maltreated children in 11 CPS investigations from 2014 to 2018. These investigations had common allegations of Inadequate Guardianship, Parent's Drug/Alcohol Misuse, Lacerations/Bruises/Welts, Inadequate Food/Clothing/Shelter, Lack of Supervision and Lack of Medical Care against the subject father and biological mother. Of these 11 investigations, 3 were indicated against the biological mother, and 1 was indicated against the subject father.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A mandated preventive services case was opened after the three CHN were discharged from foster care on 1/6/16 and placed in the care and custody of SF. SF requested assistance with being linked to appropriate services to help with SC's extensive medical needs as well as to pay for childcare. Throughout the services case, SF began working with Head Start for the twin SS, obtained medical specialists and therapists for SC, and found school placement for SC. The services case was closed on 1/13/17 as SF was able to advocate and meet his CHN's needs without child welfare intervention.

A voluntary preventive services case was opened on 8/16/14 due to BM's inability to secure housing and meet the needs of the SC, the twin SS, and a half-sibling whose biological father was not SF. On 12/4/14, the CHN were removed from BM and placed in foster care after they were found with severe diaper rashes. There were further concerns of deplorable living conditions, lack of medical care, BM's untreated mental health and substance misuse, and domestic violence. In 2015, BM gave birth to the youngest SS, and he was discharged from the hospital to SF. In January of 2016, SC and the twin SS were discharged from foster care to the care and custody of SF. The services case remained open until BM's parental rights for the half-sibling were terminated in December 2016.

Foster Care Placement History

On 9/19/18, SF voluntarily signed the CHN into foster care after his health declined and he was hospitalized for an extended period. From the hospital, SF was discharged to a rehabilitation center for the foreseeable future. The SSs were placed in foster home and SC was placed in a skilled nursing facility due to his health conditions. SF was discharged from the rehabilitation center on 4/30/19 and eligible for in-home aide services. After SF's discharge, the CHN began visitation with SF at home which progressed to overnights. The SSs were discharged out of foster care and back into SF's care and custody on 8/21/19, and SC returned home on 10/20/19. SF arranged for added supports which included in-home nursing aides and case management services to assist with his and SC's medical needs. SF appeared to be caring for the CHN appropriately and the services case was closed on 12/6/19.

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