Child Fatality Report

Report Identification Number: SY-21-020

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

Issue Date: Nov 09, 2021

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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 17 year(s)
Jurisdiction: Oswego
Gender: Male
Date of Death: 05/09/2021
Initial Date OCFS Notified: 05/14/2021

Presenting Information

An SCR report was received with concerns that on 5/9/21, the mother bathed the 17-year-old subject child and changed his diaper, and while in his bedroom, the child stopped breathing. The mother contacted 911 and police and emergency services responded. Upon their arrival, the child was unresponsive. The child was disabled and found to be severely underweight and malnourished, weighing only 55 pounds. He was also found to have severe bed sores, exposed muscle and bone, and a metal implant exposed from his hip. The child had no known conditions that would have caused his death, but the mother and stepfather were responsible for the severe neglect that contributed to such.

Executive Summary

This fatality report concerns the death of a 17-year-old male subject child that occurred on 5/9/21. A report was registered with the SCR on 5/14/21 with allegations of Malnutrition/Failure to Thrive, Inadequate Guardianship and DOA/Fatality against the child's mother and stepfather. Oswego County Department of Social Services (OCDSS) received the report and investigated the child's death. An autopsy was completed; however, the final report had not yet been released at the time of this writing. Therefore, the cause and manner of death remained pending.

At the time of the child's death, he resided with his mother, stepfather, and 13-year-old sister. The subject child's biological father was deceased. Due to a pending criminal investigation, OCDSS was prohibited from gathering all available information regarding the fatality and the concerns alleged in the report. This included conducting allegation-specific interviews with the family. It was discovered the child was diagnosed with a neurological disorder since birth, which impacted his mobility: the child was restricted to a wheelchair and needed significant care which involved assistance with eating, bathing, and toileting. Further, the child was considered medically fragile. Documentation obtained from law enforcement, medical providers, and the medical examiner revealed that at the time of the child's death, he weighed 55 pounds. He was last seen by a pediatrician on 9/1/20, where he reportedly weighed 114 pounds. There were no recent records to show the child had been seen by a doctor in the months leading up to his death. Medical documentation post autopsy revealed the child had numerous pressure sores throughout his body, some of which were so severe that bone was exposed through his skin. Law enforcement noted that they felt the child was grossly neglected. Due to the criminal investigation, it remained unknown what occurred at the time the child became unresponsive or his condition in the days leading up to his death.

From the time the investigation began to the time of this report, OCDSS regularly assessed the safety of the surviving sibling and noted no concerns. Services were offered to the family in response to the child's death. The investigation remained open and ongoing, pending receipt of the final autopsy and full interviews with the parents, sibling and collateral sources.

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?** Unable to Determine
- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
The investigation had not yet been determined 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? Yes

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

Explain:
The investigation remained open and ongoing at the time of this writing.

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: 05/09/2021 **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: 09:52 PM
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

Did child have supervision at time of incident leading to death? Unable to determine

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	17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Stepfather	Alleged Perpetrator	Male	37 Year(s)

LDSS Response

On 5/14/21, OCDSS received the SCR report regarding the death of SC, which occurred on 5/9/21. OCDSS initiated their investigation within 24 hours and coordinated their efforts with their MDT. OCDSS learned there was one SS and worked promptly to assess her safety.

On 5/14/21, OCDSS spoke with LE regarding the fatality. LE explained SC weighed 55 pounds at the time of his death and had severe bed sores covering his body. LE also noted SC's wheelchair was covered in urine, and felt SC was seriously neglected. LE stated the parents would not be interviewed until the autopsy results were received, as criminal charges were being considered. LE requested OCDSS also not interview any family members regarding the allegations until further notice, as it would interfere with their investigation, to which OCDSS agreed.

On 5/14/21, OCDSS met with SS at a friend's home where she was temporarily staying. SS reported she last saw SC briefly on the evening of 5/9/21, and he had been playing video games in his room at that time. She explained she then went to stay at her friend's house, where she often was during the week and on weekends. SS denied any safety concerns in her home or her friend's home and denied she or SC were ever deprived of food. SS stated SM would change SC's diapers for him a few times a day. OCDSS did not ask specific questions regarding SC's death per LE's request. SS was deemed safe and no concerns surrounding her care were noted.

On this same date, OCDSS accompanied LE to the family's residence. The home was observed to be free from any safety hazards. OCDSS spoke with the parents surrounding general safety and they denied drug use in the home, domestic violence, and any mental health concerns. Specific questions surrounding the fatality were not asked per LE's request. Upon leaving, LE and OCDSS observed SC's wheelchair outside of the home. OCDSS noted the wheelchair emitted a strong odor of urine, despite having been outside for several days. Further, the seat cushion was black and covered in mold, and parts of the wheelchair were rusted.

On 5/17/21, OCDSS received SC's pediatric records. It was noted SC was last seen on 9/1/20 and was a new patient at that practice. His weight was documented as 114.7 pounds; however, SC was not weighed at the doctor's office. The weight was reported to the pediatrician by SM. There were no immediate concerns noted, and SC was up to date with

immunizations. The doctor also wrote an order for SC to have a swallow test completed, but as of the date of SC's death, this was never done. It was recommended the SC be seen yearly for a well check, and additionally as needed.

On this same date, OCDSS observed LE photos taken of SC after his death. The record noted almost the entirety of SC's back was red and bleeding, and there were several places on his body where bones were exposed, the most prominent being his tailbone. Hardware from a hip implant was also exposed through the skin, and open, bleeding sores covered his buttocks. OCDSS described SC's body as appearing emaciated.

On 5/26/21, OCDSS and LE spoke with school staff, who noted concerns that SM was not repositioning SC, which caused pressure sores. There were further concerns SC's diaper was not changed enough, and his wheelchair needed adjustments that were never made. It was unclear when school staff last saw SC in person, and this information was not made available per LE's request.

Throughout the case, OCDSS assessed the safety of SS on numerous occasions. The family's account of events leading up to SC's death was not gathered due to the ongoing criminal investigation. Evidence collected noted there was a possibility of severe medical neglect that may have played a role in the fatality; however, LE was waiting for the official autopsy to be released before they investigated further. At the time of this writing, the CPS and criminal investigations remained open and ongoing.

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
Comments: This fatality investigation was conducted by the Oswego County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was submitted for review by the Oswego County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058565 - Deceased Child, Male, 17 Yrs	058567 - Mother, Female, 41 Year(s)	DOA / Fatality	Pending
058565 - Deceased Child, Male, 17 Yrs	058567 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Pending
058565 - Deceased Child, Male, 17 Yrs	058567 - Mother, Female, 41 Year(s)	Malnutrition / Failure to Thrive	Pending
058565 - Deceased Child, Male, 17 Yrs	058568 - Stepfather, Male, 37 Year(s)	DOA / Fatality	Pending
058565 - Deceased Child, Male, 17 Yrs	058568 - Stepfather, Male, 37 Year(s)	Inadequate Guardianship	Pending

058565 - Deceased Child, Male, 17 Yrs	058568 - Stepfather, Male, 37 Year(s)	Malnutrition / Failure to Thrive	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?	☒	☐	☐	☐

Additional information:

OCDSS interviewed the family and collateral sources; however, the scope of the interviews was limited due to an ongoing criminal investigation. Progress notes and other documentation were completed and entered within the required timeframes.

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 RAP was not yet completed at the time of this writing; however, services were offered to the family in response to the fatality.				

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 sibling was assessed as safe and 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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: Counseling services referrals and information regarding funeral cost assistance were provided to the family.							

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:
Grief and bereavement services were offered to the parents for the sibling in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Grief and bereavement services were offered to the parents in response to the fatality.

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? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/09/2021	Deceased Child, Male, 17 Years	Mother, Female, 42 Years	Lack of Medical Care	Unsubstantiated	Yes

Report Summary:
This SCR report was received with concerns that SC was diagnosed with a neurological disorder and had required a swallow test since 2019; however, SM failed to bring him for the test. This placed SC at risk of choking on food, not eating the appropriate foods, and aspiration pneumonia. SC was also supposed to be attending physical therapy 2 to 3 times per week, but SM was not complying with this recommendation. As a result, SC was regressing physically and appeared weak. Additionally, SC had sores on his face, discolored skin, had dark circles around his eyes and was very thin. There were also concerns SC would be left in wet diapers in the past, which would cause sores to his buttocks.

Report Determination: Unfounded **Date of Determination:** 04/16/2021

Basis for Determination:
OCDSS interviewed family and collaterals. SM reported the swallow test was elective, and the referral was made on 9/1/20; however, due to COVID, the test was delayed and then the referral expired, so the doctor sent a new one. OCDSS received information from SC's pediatrician's office regarding SC's last pediatric visit, and it noted SC was last seen in person by the doctor on 9/1/20; no concerns were noted at that visit. SC's other providers were seeing him virtually and they reported SC was compliant and saw the physical therapy assistant twice a week. SC was observed with bumps on his jaw, which SM reported was a skin condition. OCDSS also noted SC had some discoloration under his eyes but did not feel they were dark circles. SC denied being left in wet diapers and was noted to appear healthy. OCDSS last observed SC face-to-face on 4/9/21, 30 days before he died. During all interactions, SC was fully clothed and no concerns regarding his health or appearance were documented. OCDSS unfounded and closed the case.

OCFS Review Results:
The record did not reflect that SC was fully interviewed regarding general safety or the concerns in the report. The record did not reflect OCDSS obtained any information from the hospital surrounding the swallow test, when the new referral was received, or if it was elective as SM claimed.

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

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

Summary:
The record did not reflect the subject child was fully interviewed and assessed regarding general safety or all of the concerns alleged in the report.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
Throughout the CPS investigation, OCDSS must facilitate information gathering, analyses of safety factors and the inter-relatedness of risk influences and individual risk elements affecting family functioning.

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The record did not reflect OCDSS obtained any information from the hospital surrounding the swallow test, when the new referral was received, or if it was elective as the mother claimed.

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

Action:

OCDSS 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)
05/12/2020	Deceased Child, Male, 16 Years	Mother, Female, 42 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Deceased Child, Male, 16 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 16 Years	Mother, Female, 42 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 16 Years	Mother, Female, 42 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepfather, Male, 36 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepfather, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepfather, Male, 36 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 16 Years	Stepfather, Male, 36 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
This SCR report was received with concerns SC was diagnosed with a neurological disorder and needed a swallow test due to coughing and struggling while eating; however, it was never completed. There were further concerns SC's cheeks were sunken in and he was very thin, as he was not receiving adequate nutrition. Additionally, SC was not attending his physical and occupational therapies as required, and SM nor SF were repositioning him in his wheelchair as needed. As a result, SC suffered from bedsores and the bandages were not changed regularly. Lastly, there were concerns SC would be left in soiled diapers for extended periods of time and needed a new wheelchair.

Report Determination: Unfounded | **Date of Determination:** 12/17/2020

Basis for Determination:
OCDSS interviewed family, SC's pediatrician, and service providers. All noted SM made appointments to address alleged concerns; however, due to COVID, they were being rescheduled or canceled on behalf of the providers. The aide was concerned SC was malnourished; however, the pediatrician noted no concerns regarding weight or SC's ability to swallow. The swallow test and wheelchair fitting were ordered but both were delayed due to COVID. SC was interviewed and observed on several occasions with no noted concerns. SC was compliant with all services. All services were virtual due to the pandemic. The family denied the concerns in the report. 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)
04/23/2019	Deceased Child, Male, 15 Years	Stepfather, Male, 35 Years	Inadequate Guardianship	Substantiated	Yes

Deceased Child, Male, 15 Years	Stepfather, Male, 35 Years	Lacerations / Bruises / Welts	Substantiated
Deceased Child, Male, 15 Years	Mother, Female, 41 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 15 Years	Mother, Female, 41 Years	Lacerations / Bruises / Welts	Substantiated

Report Summary:
This SCR report was received with concerns SC was wheelchair-bound, and for 12 days over school break, SC was only moved from his chair to sleep. The parents were aware he needed to be repositioned but left him in the chair for extended periods of time regardless. As a result, SC sustained open sores on his hip and underarm. Further, the wheelchair cushion was saturated in urine and covered in mold. SC's pants would become wet because of the seat. A SUB report was received on 6/12/19 which alleged the same concerns.

Report Determination: Indicated | **Date of Determination:** 07/19/2019

Basis for Determination:
OCDSS interviewed family and collaterals. Pictures of SC's wheelchair were observed and noted the wheelchair pad had green and black stains on it. OCDSS spoke with the family and all denied the allegations. During the investigation, SC was measured for a new wheelchair. School staff reported that other than hygiene concerns, SC seemed like a healthy child. OCDSS indicated and closed the case.

OCFS Review Results:
The allegations were not fully explored. SC was not asked about sores on his body or toileting. Contact with medical providers was not documented. On 6/20/19, OCDSS observed photos of SC's wheelchair pad covered in stains and mold. This was not addressed further with the parents. School staff explained insurance could cover the cost of new chair pads; however, this was not followed up with. Concerns surrounding existing open sores reported by school staff or staff's failed attempts to engage SM regarding ongoing issues were not explored. OCDSS did not follow up with the parents to ensure SC was using the appropriate incontinence supplies. The record did not reflect if services were offered.

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

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

Summary:
The allegations and concerns were not fully explored: SC was not asked about sores on his body or toileting. The moldy and stained wheelchair pad was not addressed with SM or SF. School staff's concerns were not addressed with SM or SF. OCDSS did not follow up with SM to ensure SC was utilizing the appropriate incontinence supplies.

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

Action:
Prior to making a determination, OCDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Issue:
Failure to Offer Appropriate Services

Summary:
The record did not reflect if services were offered to the family.

Legal Reference:
SSL §424(10);18 NYCRR 432.3(p)

Action:
OCDSS will offer families available services that are appropriate for the child(ren), the family, or both, prior to case closing.

Issue:
Failure to provide notice of report
Summary:
The record did not reflect if Notice of Existence Letters were sent regarding the subsequent report that was received.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
OCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The record did not reflect if SC's medical providers were contacted.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
OCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

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

From 2012 to 2017, the family was involved in five FAR investigations with common allegations of XCP, IG, L/B/W, LMC, and IF/C/S.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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

Additional Local District Comments

Thank you for acknowledging the fatality report has been done completely and properly to date. Given high caseload sizes, significant staffing issues and the worldwide pandemic, we will do our best going forward. The current cause of death is pending. Several service providers indicated there were no current concerns in the most recent investigation. They all indicated both mom and child were fully engaging in necessary services. These providers saw the child multiple times per week with no concerns through out the investigation and case closure.

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