Child Fatality Report

Report Identification Number: SY-21-052

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

Issue Date: May 26, 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		
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: 2 year(s)
Jurisdiction: Oneida
Gender: Male
Date of Death: 12/06/2021
Initial Date OCFS Notified: 12/07/2021

Presenting Information

An SCR report was received which stated that on 12/5/21, the two-year-old subject child was being cared for by the maternal aunt and her boyfriend. The child went to bed at their home, and shortly before midnight, the maternal aunt and her boyfriend found the child not breathing and unresponsive. Emergency services were called and the child was transported to the hospital where he was pronounced deceased. The maternal aunt and her boyfriend provided no explanation for the subject child's death, and the roles of the mother and father were unknown.

Executive Summary

This fatality report concerns the death of a two-year-old male subject child that occurred on 12/6/21. A report was registered with the SCR on 12/7/21 with allegations of Inadequate Guardianship and DOA/Fatality against the child's maternal aunt (MA) and the maternal aunt's boyfriend (OA). Oneida County Department of Social Services (OCDSS) received the report and investigated the child's death. An autopsy was performed; however, the completed report remained pending at the time of this writing.

At the time of the child's death, he was staying the weekend at his father's home, which he shared with the maternal aunt, the maternal aunt's boyfriend, their two children (two and four years old) and an unrelated roommate (UHM). The mother lived in a different residence, and she and the father shared custody of the child. The maternal aunt and her boyfriend regularly babysat the child while the parents were at work, which included the weekend of 12/3/21. The investigation revealed that the subject child had a recent history of medical issues; however, he had been acting normally and without concern in the days leading up to his death. At approximately 6:00PM on 12/5/21, the father went to work and left the child in the care of the maternal aunt and her boyfriend. At 6:30PM, all three children had dinner, and at 9:30PM, the maternal aunt's children went to bed while the subject child watched television in the living room. At an unknown time, the subject child went to sleep, and at around 10:30PM, the maternal aunt's boyfriend checked in on him. The child was laying in an "awkward manner," and appeared weak. The boyfriend gave the child Pedialyte, and reported the child seemed to "perk up" afterward. The maternal aunt and boyfriend then tucked the child back in and he went back to sleep. The maternal aunt's boyfriend again checked on the child around 11:45PM and saw he needed his diaper changed. While doing so, the boyfriend noticed the child was acting strangely, and then stopped breathing. There was no elaboration as to the child's behaviors at the time of the incident. Emergency services were called, and paramedics responded to the home. The subject child was taken to the hospital via ambulance where he was pronounced deceased at 12:50AM on 12/6/21.

OCDSS spoke with family members and collateral sources, which included law enforcement, first responders, hospital staff, the subject child's pediatrician, and the medical examiner. At the time of this writing, there were no criminal charges brought against any of the child's caregivers. The maternal aunt and her boyfriend's children were observed on more than one occasion and deemed safe. The medical examiner noted the child had a lacerated liver but stated this was a common injury during cardiopulmonary resuscitation. Grief and bereavement service referrals were provided to the family following the fatality. The CPS investigation had not yet been determined at the time this report was issued, and investigation closure was pending receipt of the final autopsy.

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?** No, sufficient information was not gathered to determine any of the allegations.
- **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? No

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

Explain:
As of the date of this writing, the fatality investigation remained open and ongoing; however, the record did not reflect if the allegations and other information gathered during the investigation were explored fully with the family, others present in the household, and collateral sources. This included: lack of follow up with medical providers regarding discrepancies in information received from doctors and family members; an accurate timeline of events that occurred leading up to the fatality; follow-up questions surrounding the family members' claims that the subject child was medically frail his entire life.

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: 12/06/2021 **Time of Death:** 12:50 AM

Date of fatal incident, if different than date of death: 12/05/2021

Time of fatal incident, if different than time of death: 11:45 PM

County where fatality incident occurred: Oneida
Was 911 or local emergency number called? Yes
Time of Call: 11:46 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: Diaper Change

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☐ 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	Aunt/Uncle	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Father	No Role	Male	22 Year(s)
Deceased Child's Household	Other Adult - Maternal Aunt's Boyfriend	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	4 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	2 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	26 Year(s)
Other Household 1	Mother	No Role	Female	22 Year(s)

LDSS Response

On 12/8/21, OCDSS met with the family. Numerous family members were present, including BM, BF, MA, OA, UHM, and MA and OA's 2 CHN. MA and OA were interviewed and reported SC came to their home on 12/3/21 to stay for the weekend because BM had to work. They explained BF lived in the home, and they watched and cared for SC regularly. MA described SC as frail, and he had recently had blood work with abnormal results. MA explained over the past 2 weeks, SC "had really gone downhill and was very lethargic," but then stated SC was his "normal self" over the weekend and was running around having fun. MA and OA reported there were no issues with SC from 12/3/21 to 12/5/21. They stated on 12/5/21, BF went to work around 6:00PM, and SC was fine at that time. MA and OA said they had dinner around 6:30PM and at 8:00PM, a client arrived for a scheduled appointment, as OA was a tattoo artist and had his shop inside the home. MA said at 9:30PM, her and OA's CHN went to bed; however, SC stayed up watching television. Both reported their younger CH woke up crying around 10:30PM, and after OA tended to him, he checked on SC. OA said he found SC

sleeping in an "awkward manner," and appeared pale and weak, so he gave SC some Pedialyte. SC "perked right up" and he and MA tucked him back into bed. When OA next checked on SC at 11:45PM, he noticed he had wet his diaper, so he brought SC into his room to change him. OA said that while doing so, SC "was just lying there and acting weird." OA reported he asked SC if he was okay, and SC nodded his head, but then stopped breathing. MA started CPR while OA called 911. OA explained when EMTs arrived, they were able to regain a faint pulse. OA said he then called BF to tell him what happened, and everyone got a ride to the hospital. OCDSS attempted to interview MA and OA's CHN, but they would not engage. The record did not reflect what time SC went to bed or where in the house he slept.

On this same date, OCDSS interviewed BM and BF. BM explained SC had always had medical issues but was never diagnosed with anything. She reported he had a poor appetite, was frail, and after he turned 2, he started to lose his hair. BM said SC was diagnosed with a developmental delay in September 2021 and they were in the process of getting him services. BM said SC's most recent blood work was so abnormal that the Dr. thought there was a lab error and reordered the labs twice; each time they remained abnormal. BM stated she received the latest results on 12/3/21 and asked the Dr. if she should bring SC in to be seen that day. The Dr. reported it could wait until after the weekend, as SC already had a follow-up appointment scheduled for 12/6/21. BF said SC was fine all weekend and neither he nor BM had any reason to believe something like this would happen. Neither parent reported any concerns regarding MA or OA's care of SC.

OCDSS spoke with UHM who reported he had no information regarding the incident, as he was in his bedroom. He explained at one point he heard screaming, and that was when he learned SC was not breathing. UHM denied any safety concerns surrounding the care provided to SC.

OCDSS obtained records from SC's Dr. as well as past hospital visit records. The hospital records noted SC was seen on 9/28/21 for a burn to his hand, and again on 11/22/21 with a complaint of hair loss, lack of appetite, vomiting and low blood count. The burn on SC's hand was also evaluated on that date and noted to not have healed properly. The ER Dr. provided BM with a referral for a specialist regarding the burn; however, the record did not reflect if there were any additional recommendations regarding the other concerns. The pediatrician's records noted SC was up to date medically and attended well child checkups. In April 2021, records indicated SC had a tibia fracture that healed properly. SC was seen on 11/15/21 for his 30-month checkup, and the Dr. noted SC's weight decreased from his last visit in September, and his height percentile also decreased. At that visit, SC presented with a healing burn on his right hand and was unable to make a fist. The Dr. referred SC to an orthopedic surgeon; however, the record did not reflect if the parents followed through with this. The record also did not reflect if the either Dr. was made aware of how the burn was sustained.

On 12/17/21, OCDSS spoke with SC's Dr. via phone. The Dr. confirmed SC's lab work from 11/22/21 and 12/3/21 were highly abnormal, and he initially attributed it to a lab error. The Dr. explained on 12/3/21 he called BM himself because he was so concerned and told her he wanted to repeat labs the following morning, on 12/4/21. The Dr. stated he "stressed this was a critical lab." The Dr. stated if the lab results were in fact accurate and not an error, they would likely have been caused by internal bleeding. He further stated SC's hair loss could have been indicative of a nutrition deficiency. The record did not reflect any follow up questions were asked of the Dr. regarding the parents' failure to bring SC for testing on 12/4/21. The record did not reflect if OCDSS asked the Dr. about the family's claim that SC was medically frail for most of his life, or if the internal bleeding could have been caused by a medical issue.

OCDSS spoke with the parents who were adamant the Dr. said the follow up testing could wait until 12/6/21. OCDSS also spoke with additional staff at the Dr.'s office, and conflicting information was obtained: A lab order for 12/4/21 was not found, and the last order was for the labs completed on 12/3/21. Further, it appeared some tests were cancelled after the blood was drawn. The record did not reflect any additional contact with the Dr. to clarify discrepancies.

OCDSS attempted to interview MA and OA's CHN on two occasions but were unsuccessful. LE reported their investigation would be closed with no charges if the autopsy did not show anything of concern. The CPS investigation had not yet been determined at the time of this writing and remained open pending the completed autopsy results.

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 Oneida County Multidisciplinary Team.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was referred to the Oneida County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060414 - Deceased Child, Male, 2 Yrs	060416 - Aunt/Uncle, Female, 23 Year(s)	DOA / Fatality	Pending
060414 - Deceased Child, Male, 2 Yrs	060416 - Aunt/Uncle, Female, 23 Year(s)	Inadequate Guardianship	Pending
060414 - Deceased Child, Male, 2 Yrs	060417 - Other Adult - Maternal Aunt's Boyfriend, Male, 27 Year(s)	DOA / Fatality	Pending
060414 - Deceased Child, Male, 2 Yrs	060417 - Other Adult - Maternal Aunt's Boyfriend, Male, 27 Year(s)	Inadequate Guardianship	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. 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	☐	☐	☐	☒

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 other children in the father's household 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:
OCDSS offered the family services in response to the subject child's death, which included bereavement counseling and funeral cost assistance.

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:
OCDSS provided the family with grief and bereavement service referrals for the other children that lived in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS provided the family with grief and bereavement referrals following the death of the subject child.

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? N/A
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)
09/24/2021	Deceased Child, Male, 2 Years	Father, Male, 21 Years	Burns / Scalding	Unsubstantiated	Yes
	Deceased Child, Male, 2 Years	Father, Male, 21 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Father, Male, 21 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that on 9/23/21, the subject child sustained a 2nd degree burn on his right hand, covering the entire upper side of the hand, a portion of the wrist, and three fingers. The burn blistered and several of the blisters ruptured. The nature of the injury was inconsistent with the father's explanation. The father failed to seek adequate medical care for the burn and treated it by placing three bandages around each of the burned fingers.

Report Determination: Unfounded **Date of Determination:** 12/01/2021

Basis for Determination:
OCDSS interviewed the BM, BF, and OA. OA was caring for SC when he was burned. He explained he had SC on the counter while he was doing dishes. The water was running, and the water in the home could get "boiling hot." OA said he then went to check on his CHN and when OA returned, SC was screaming, rubbing the back of his hand on his pants. OA said he called BF and told him to buy burn cream. OA called his wife (the record did not reflect if this person was MA) who was a nurse and told OA to wrap SC's burn until SC could get to a hospital. BF called BM, who took SC to the ER. BF reported SC had a sensory disorder and would not have felt how hot the water was right away. BF stated he would

turn down the boiler in the home so the water would not get so hot. OCDSS reviewed supervision with the family and closed the case.

OCFS Review Results:
Notice of Existence letters were not sent until 10/27/21. OA was a person legally responsible for SC, but OCDSS did not add him as a subject to the case after learning he was supervising SC at the time of the incident. The record did not reflect if OCDSS tested the water to confirm OA's story of how hot the temperature could get, nor did it reflect OCDSS checked to be sure BF decreased the boiler temperature. The record did not reflect if OCDSS spoke with medical professionals to verify if the explanation was consistent with the injury. OA's CHN were not added to the report, were never observed, nor was their safety assessed. OA's wife was not added to the report.

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

Issue:
Failure to provide notice of report
Summary:
Notice of Existence letters were not sent until 10/27/21, 26 days past the required timeframe.
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:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The record did not reflect if the maternal aunt's boyfriend's children were observed or their safety assessed. Further, OCDSS did not confirm the father turned down the temperature of the boiler to prevent the water from running so hot.
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:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
The record did not reflect if OCDSS spoke with medical professionals to verify if the explanation provided was consistent with the injury.
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.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The Seven Day Safety Assessment noted all family members were seen and interviewed; however, the maternal aunt had not been interviewed, nor were her and her boyfriend's two children seen or assessed.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
Within seven days of receiving a report, OCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/19/2021	Deceased Child, Male, 1 Years	Father, Male, 21 Years	Fractures	Unsubstantiated	Yes
	Deceased Child, Male, 1 Years	Father, Male, 21 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Years	Other Adult - Cousin, Male, 22 Years	Fractures	Unsubstantiated	
	Deceased Child, Male, 1 Years	Other Adult - Cousin, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Years	Other Adult - Cousin's Wife, Female, 21 Years	Fractures	Unsubstantiated	
	Deceased Child, Male, 1 Years	Other Adult - Cousin's Wife, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns SC had a spiral fracture of the mid and distal left tibia. The father's explanation for the injury was not plausible.

Report Determination: Unfounded | **Date of Determination:** 07/27/2021

Basis for Determination:
OCDSS interviewed BF who reported he and SC were at a family function on the date of the incident and did not see SC do anything to injure himself, but he was playing with other CHN. BF reported when he awoke the next morning, he noticed SC could not put weight on his leg and was crying. BF took SC to the hospital and a spiral fracture was found. BF reported he did not know how it occurred. BM denied any concerns surrounding BF's care for SC. BF's roommates denied any information regarding the fracture and denied safety concerns. OCDSS spoke with the orthopedic Dr. who treated SC, and noted what BF told that Dr. was consistent with what he reported to OCDSS. The case was unfounded and closed.

OCFS Review Results:
This investigation was not adequately investigated. OCDSS did not fully explore the allegations in the report, did not follow up with pertinent collateral sources, did not assess the safety of the one-year-old cousin who also lived in the home within the required timeframe, and did not accurately document safety factors present. Additionally, there was not enough information gathered to appropriately determine the investigation.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
OCDSS did not fully explore the allegations in the report. An emergency room doctor who treated the subject child's fracture reported to OCDSS that the father's "story was not very good, and details stunk." This doctor felt the injury was suspicious, as a spiral fracture required twisting, or possibly stepping into a hole in the ground. OCDSS did not ask any follow up questions, including how easily a child the subject child's age could sustain such an injury, how a child that age would act immediately after sustaining such an injury, or if it could go unnoticed until the following day. The record did not reflect a timeline as to how long the father and subject child were at the family function or who was there that could have been contacted as collateral sources. OCDSS did not ask for details surrounding supervision of the subject child

while at the function, how the subject child was playing with the other children or how those children interacted with the subject child. The mother reported she was informed the injury was not a spiral fracture; however, OCDSS did not explore this further. The orthopedic doctor's report was obtained by OCDSS, and it stated the injury was "a spiral fracture of tibula fracture," but OCDSS did not ask for clarification as to what that meant, as a tibula is not a body part and it was unclear what the actual injury was. The roommates who were also named as subjects in the report had a one-year-old child; however, this child was not seen or assessed until 7/15/21. OCDSS assessed the safety of the subject child, who was a nonverbal one-year-old with a suspicious, unexplained fracture while in the care of the father, and deemed the child safe to remain in the care of the father and his roommates. A Safety Plan should have been implemented until further information was obtained and safety of the child could be adequately assessed. By the close of the investigation, it remained unclear as to how the child sustained the injury; however, OCDSS unfounded and closed the case without sufficient information to determine the allegations.

Legal Reference:

SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:

OCDSS will review and adhere to regulations regarding casework practice. OCDSS will complete collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

[redacted]

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

There was no known CPS history outside of New York State.

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