# Child Fatality Report

## Report Identification Number: NY-18-043

## Prepared by: New York City Regional Office

## Issue Date: Aug 16, 2018

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 | | |

## Case Information

**Report Type:** Child Deceased
**Age:** 5 month(s)
**Jurisdiction:** Bronx
**Gender:** Male
**Date of Death:** 04/28/2018
**Initial Date OCFS Notified:** 04/28/2018

### Presenting Information

Two SCR reports were made on 4/28/18 regarding the death of the 5-month-old SC. Together, the reports alleged on 4/28/18 at 3am, SC was awake and responsive as SM fed him, then both parents placed him in his crib to sleep. Around 10am/10:30am, the parents checked on SC and noticed he was unresponsive in his crib, where he was lying face up on top of a blanket. SM called 911 at 11:17am, EMS arrived and attempted to resuscitate SC, then SC was transported to the hospital where he was pronounced dead. The death was deemed suspicious as neither parent had an explanation for SC's death, and there was a significant delay in obtaining medical treatment after finding him unresponsive. There were 2 other children noted to be residing in the home, and their roles were unknown.

### Executive Summary

On 4/28/18, ACS began investigating the death of the 5-month-old SC following the receipt of 2 SCR reports. The first report alleged both parents were the last to see the SC alive, and had both found him unresponsive, without the ability to provide a reasonable explanation. The second report only noted the SM as being present and responsible.

ACS corresponded with LE in the first 24 hours and learned information LE had already gathered. ACS spoke with the source and made all appropriate notifications. It was not apparent that ACS investigated alongside LE aside from the initial contacts. No known arrest has been made to date.

ACS learned the circumstances surrounding the fatality from interviews with the family and collateral contacts. SM and SF reported they were both home with SC the last time he was seen alive; both SS were at MGM's home. SM fed SC around 10:30pm on 4/27/18, then placed him to sleep on his back in a portable crib. Both parents had one glass of wine each, and SM went for a walk in the neighborhood around 1:30am. Around 3:30am, SC woke for a feeding and SM breastfed him for about 15-20 minutes. SM placed SC back to sleep in the crib, positioned on his back. A sheet and 3 small stuffed animals were at the foot of the crib. SM and SF went to sleep, and SF left the home at 7am, seeing what he saw to be SC asleep in the crib. Sometime between 10 and 11am on 4/28/18, SM awoke and found SC unresponsive, in the same position in which she had placed him to sleep. SM called MGM and 911, but she was unsure who she called first, noting she was in panic. SM administered CPR as instructed over the phone. EMS transported SC to the hospital, arriving at 11:41am, and efforts to resuscitate were unsuccessful. SC was pronounced deceased at 11:54am.

ACS questioned the parents about their alcohol use the night of the fatality, as a nurse at the hospital reported SM smelled of alcohol upon arrival, but noted she did not appear intoxicated. SM and SF both maintained they only had 1 glass each. Collateral contacts were inquired of this, and no one else observed that SM smelled of alcohol or appeared intoxicated. ACS enlisted the assistance of a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and requested drug and alcohol screenings. SM completed such and was negative for all substances; BF declined to participate.

ACS saw and interviewed both SS, and no concerns were noted. The 13yo SS had been residing with MGM since the death of MGF the previous year, but came to her family's home frequently. ACS discussed grief services for the SS with SM, and extended the offer to the parents.

ACS held a Child Safety Conference (CSC) on 4/30/18 and decided to file for court-ordered supervision of services: parenting classes, counseling, and drug/alcohol assessment/treatment. ACS attempted to file in Family Court on 5/2/18, though it was not clear which parent (or both) were being filed against, and the following concerns were presented: SM

consumed alcohol then breastfed, SM failed to seek medical attention when SC stopped breathing the night prior (though this information was not noted in the case record of interviews), and SF admitted to marijuana use. The request was denied, citing specific information still needed to be gathered to have sufficient grounds to file. ACS followed up, but there was still necessary information that was pending autopsy results. ACS opened a Preventive Services case, though the family declined services throughout the length of the case. To date, ACS has not completed any FASPs.

On 4/29/18, the ME noted tests conducted were negative for injuries or trauma, though further tests were pending. ACS informed the family their plan was to keep the investigation open until the autopsy results came back. At the time this fatality report was written, ACS's investigation remained open, as well as the Preventive Services case, though there was no activity within the Services case.

**PIP Requirement**

ACS will submit a PIP to the New York City Regional Office within 30 days of receipt of this report. The PIP will identify action(s) ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

**Determination:**

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

**Explain:**

The Investigation Determination Safety Assessment had not been completed, as the investigation remained open at the time of the writing of this report.

| | |
|---|---|
| **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 notes a consultation took place, but no details noted. |

**Explain:**
The investigation remained open at the time of the writing of this report. Additionally, the Preventive Services case remained open, with no casework activity or FASPs completed to date.

**Required Actions Related to the Fatality**

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

| | |
|---|---|
| **Issue:** | Adequacy of Risk Assessment Profile (RAP) |
| **Summary:** | An Elevated Risk Factor was selected which stated the caretaker(s) was/were responsible for the death of the child, though ACS had not gathered sufficient information to make this conclusion at the time the RAP was completed. |
| **Legal Reference:** | 18 NYCRR 432.2(d) |
| **Action:** | ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the RAP, which reflect what is known at the time the RAP is completed. |
| | |
| **Issue:** | The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment. |
| **Summary:** | The 30-Day Fatality Report was 14 days late. |
| **Legal Reference:** | CPS Program Manual, Chapter 6, K-2 |
| **Action:** | The Child Protective Service (ACS) is required to complete the 30-Day Fatality Report within 30 days of receipt of a report alleging the death of a child as a result of child abuse or maltreatment. |
| | |
| **Issue:** | Timely/Adequate 30-Day Safety Assessment |
| **Summary:** | The 30-day safety assessment was 15 days late. |
| **Legal Reference:** | CPS Program Manual, Chapter 6, K-2 |
| **Action:** | ACS will complete all safety assessments in the amount of time required. |
| | |
| **Issue:** | Timely/Adequate Case Recording/Progress Notes |
| **Summary:** | The subsequent report was not consolidated, and though not required, the second report was not stage-progressed from intake to investigation for over 1 month which resulted in untimely documentation of progress notes. |
| **Legal Reference:** | 18 NYCRR 428.5 |
| **Action:** | All progress notes will be entered as contemporaneously as possible to their event dates. |
| | |
| **Issue:** | Adequacy of Documentation of Safety Assessments |
| **Summary:** | The subsequent report was not consolidated, and though not required, the second report was not stage-progressed from intake to investigation for over 1 month which resulted in untimely documentation of safety assessments. |
| **Legal Reference:** | 18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b) |
| **Action:** | ACS will complete all safety assessments in the amount of time required. |
| | |

## Fatality-Related Information and Investigative Activities

## Incident Information

**Date of Death:** 04/28/2018 **Time of Death:** 11:54 AM

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

**County where fatality incident occurred:** Bronx
**Was 911 or local emergency number called?** Yes
**Time of Call:** 11:17 AM
**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?** Yes
**How long before incident was the child last seen by caretaker?** 6 Hours
**Is the caretaker listed in the Household Composition?** Yes - Caregiver 1
**At time of incident supervisor was:**

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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 | 5 Month(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 35 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 33 Year(s) |
| Deceased Child's Household | Sibling | No Role | Male | 4 Year(s) |
| Other Household 1 | Sibling | No Role | Female | 13 Year(s) |

## LDSS Response

Within 24 hours of the report, ACS interviewed SM and SF and assessed safety of the SS. The parents planned for the SS to stay at relatives' homes, which ACS assessed as safe/appropriate. ACS later observed the family's home, though they did not stay there after the fatality. The family remained together, with relatives, whose home was observed and deemed safe/appropriate.

SM, SF, and SS were interviewed once by ACS's Emergency Services (ECS) and again by the Child Protective Specialist. In summary, SM said around 10/10:30pm on 4/27/18 she gave SC a bottle and placed him to sleep on his back in a portable crib. She had 1 glass of wine then went for a walk, leaving SC sleeping in SF's care. She returned 20-30 minutes later. SC woke around 3:30am; SM breastfed him, then placed him on his back in the portable crib at 4am. SM noted she was conscious about consuming alcohol and breastfeeding, and felt enough time had passed. In the crib were 3 small stuffed animals along the foot of the crib along with a sheet, all which SM said were out of SC's reach. SM woke around 10/11am and found SC unresponsive, in the same position in which she had placed him to sleep, with nothing obstructing his breathing. SM performed CPR after calling 911. She could not recall whether she called 911 or MGM first.

Between the 2 interviews of SF, there were variations in his account. Initially, SF reported observing SM administer both feedings to SC, and saw SM put SC to sleep on his back in the crib prior to waking with SM and finding SC unresponsive, saying he called 911. SF later reported he did not observe the 2nd feeding or see how SC was put to sleep; and, he noted he left the home at 7am that morning. The record noted workers had yet to seek clarification from SF on the discrepancies.

The 13yo SS was interviewed. She last saw SC on 4/27/18, noting he was happy and jumping around. She and the 4yo SS left the home around 7pm to stay at MGM's home for the weekend. The 13yo SS overheard MGM's phone conversation with SM upon SM finding SC unresponsive, and heard MGM yell to SM to call 911. The BF of the 13yo SS was contacted, and he did not express any safety concerns for BM's care of SS. The 4yo SS was seen and efforts were made to engage him in an interview. No concerns were revealed for either CH.

SM and SF said they both drank 1 glass of wine on 4/27/18, and both denied intoxication or drug use. Collateral contacts did not have concern for SM or SF abusing drugs/alcohol, though an ER nurse noted smelling alcohol on SM's breath upon arrival at the hospital; however, the attending Dr. and first responding LE officer did not have the same observation. SF admitted to smoking marijuana, but not around or while caring for CHN. ACS utilized a CASAC specialist, and held a CSC to discuss services. The family declined services throughout the length of the case. Efforts were made to take legal action/compel services, though ACS was denied without first clarifying necessary information.

SM said SC had a history of chronic congestion and an ongoing respiratory illness, congested the night of the incident. SC had a history of respiratory complications after birth, prior to being medically cleared 1 month later. SC's Dr. prescribed medications to treat congestion before he was 2 months old. SC was last at the Dr. on 3/4/18 and treated for wheezing, and prescribed a humidifier in addition to medications. SM did not state whether she used any medications or remedies on the night the SC passed away. SC's Dr. confirmed a history of congestion/coughing. The Dr. mentioned administering treatment, but ACS did not inquire as to when SC was supposed to be taking medication and if there was concern over compliance with any regimen. The Dr. noted SM was consistent with SC's visits and acted appropriately in his care. The parents said they were knowledgeable of safe sleep practices.

ACS continued to visit the family in an ongoing assessment of safety/risk to the SS.

## Official Manner and Cause of Death

**Official Manner:** Pending
**Primary Cause of Death:** Undetermined if injury or medical cause
**Person Declaring Official Manner and Cause of Death:** Medical Examiner

## Multidisciplinary Investigation/Review

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

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?**No

**Comments:** There is no OCFS approved Child Fatality Review Team in the New York City region.

**SCR Fatality Report Summary**

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 046805 - Deceased Child, Male, 5 Mons | 046899 - Father, Male, 35 Year(s) | Inadequate Guardianship | Pending |
| 046805 - Deceased Child, Male, 5 Mons | 046898 - Mother, Female, 33 Year(s) | Inadequate Guardianship | Pending |
| 046805 - Deceased Child, Male, 5 Mons | 046898 - Mother, Female, 33 Year(s) | DOA / Fatality | Pending |
| 046805 - Deceased Child, Male, 5 Mons | 046899 - Father, Male, 35 Year(s) | DOA / Fatality | 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:**
The 30-day safety assessment was 15 days late, and the 30-day fatality report was 14 days late.

**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 safety 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?** | ☐ | ☐ | ☒ | ☐ |
| **Explain:**<br>The 30-day Safety Assessment was completed 15 days late. | | | | |

**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:**<br>Services were offered but refused. ACS tried to file a Neglect Petition in an effort to compel services, but information was deemed insufficient to file at that time. ACS opened a Preventive Services case without the family's consent and the family declined to participate. ACS also provided information on services related 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?** | ☐ | ☒ | ☐ | ☐ |

**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:**
ACS referred the family for Preventive Services and opened a services case, though services were not being utilized. To date, SM took one drug/alcohol screening, which was negative.

**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?** No
**Explain:**
Bereavement services were offered for the SS through the SM, though it was not apparent whether any services were being used at the time this report was written.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** No
**Explain:**
Bereavement services were offered to the parents, though it was not apparent whether any services were being used at the time this report was written.

## History Prior to the Fatality

### Child Information

| | |
|---|---|
| **Did the child have a history of alleged child abuse/maltreatment?** | No |
| **Was there an open CPS case with this child at the time of death?** | No |
| **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 |

### Infants Under One Year Old

**During pregnancy, mother:**

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

**Infant was born:**

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

## CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There is no CPS history more than 3 years prior to the fatality.

### Known CPS History Outside of NYS

There is 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