



Report Identification Number: NY-18-120

Prepared by: New York City Regional Office

Issue Date: May 15, 2019

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: 1 month(s)

Jurisdiction: Bronx
Gender: Female

Date of Death: 11/17/2018
Initial Date OCFS Notified: 11/17/2018

Presenting Information

On the evening of 11/16/18, the SM was co-sleeping with the six-week-old infant. On 11/17/18, at 7:05 AM, the SM awoke and found the SC unresponsive. The SM called 911 and immediately initiated CPR. The SC was transported to Bronx Lebanon Hospital where she was pronounced dead at 7:50 AM. The allegations were DOA/Fatality and IG of the SC by the SM.

On the following day, the SCR registered a second report which contained the same information and no additional allegations.

Executive Summary

The SCR registered a report regarding the death of the SC that occurred on 11/17/18. The report narrative alleged that the SM placed the SC to sleep in the bed with her and awoke the following morning to find the SC unresponsive. The cause of the SC's death was unknown.

Following the receipt of the report, an ACS Bronx Field Office Specialist contacted LE and obtained information regarding the incident. ACS learned the SM went to sleep at approximately 11:00 PM on 11/16/18, with the SC in her bed and awoke around 7:00 AM and at that time she observed the SC wedged underneath her and the bed. LE reportedly received the call for medical assistance at 7:05 AM. LE arrived at the home at 7:15 AM to find the FD had responded and transported the SC to Bronx Lebanon Hospital (BLH) where she was pronounced dead at 7:50 AM. LE reported the SM was taken into custody and released. At the time of the incident, there were two minor children in the home, a two-year-old uncle of the SC and a twelve-year-old sibling (SS). Due to the incident, the SM arranged for the children to stay with the MGM for a few days.

The Specialist contacted BLH ER and learned from the Dr. that bruising was observed on the SC's face and likely occurred during CPR. The Dr. said there were no visible signs of trauma found on the SC that indicated maltreatment or abuse. The Dr. added that the SM stated she woke up lying on top of the SC.

On 11/17/18, the Specialist visited the family's and learned from the SM that the SC was born at Columbia Presbyterian Hospital, where she remained for one week due to complications. However, her last medical exam was on 11/7/18 and there were no concerns. The SM explained the SC ate well and did not display any signs of illness prior to her demise. The SM stated she had never receive safe sleep instructions prior to the incident. The MU and SS were in the care of the MGM at the time of the home visit and the SM refused to divulge the MGM's address, stating the SS were not aware of the SC's death. The SS were assessed as safe on 11/18/18. According to the SM, the BF was not involved in the SC's life. On 11/20/18, ACS held a Child Safety Conference at the field office and the SM disclosed she drank three beers and a glass of wine prior to going to sleep on the night of the fatal incident. She stated she was not intoxicated. As a result of the admission, ACS attempted to file an Article Ten Petition of neglect; however, the court delayed for additional information. The SM tested negative for drugs and she initiated services. ACS decided not to pursue the petition.

On 2/8/19, ACS inappropriately unsubstantiated the allegations of DOA/fatality and IG of the SC by the SM citing the ME's preliminary report that the cause of death was accidental and no foul play was found by the Dr. and LE.

Findings Related to the CPS Investigation of the Fatality



Safety Assessment:

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

Determination:

- Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation? Yes, sufficient information was gathered to determine all allegations.
- Was the determination made by the district to unfound or indicate appropriate? No

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:

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Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	On 2/9/19, ACS unsubstantiated the DOA/Fatality and IG allegations of the 11/17/18 report. However, it appears there was some credible evidence to support the substantiation of the IG allegation. ACS did not consider the SM's documented alcohol cons
Legal Reference:	FCA 1012 (e) & (f); 18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information



Date of Death: 11/17/2018

Time of Death: 07:50 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:

07:05 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? 7 Hours

At time of incident supervisor was:

Drug Impaired

Absent

Alcohol Impaired

Asleep

Distracted

Impaired by illness

Impaired by disability

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	Adult Sibling	No Role	Male	26 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Other Child - nephew	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	24 Year(s)

LDSS Response

On 11/17/18, the ACS Specialist responded to the report registered by the SCR regarding the death of the SC by contacting BLH to obtain information regarding the incident.

On the same day, the Specialist obtained information from the first responders, LE, Dr., ME and the SM that the SC appeared to be a well cared for infant with whom the SM shared a bed. On the night of the incident, the SM drank three beers and a glass of wine prior to sleeping with the SC; however, she reported she was not intoxicated. The SM awoke in the morning to find she had been sleeping on top of the SC who was unresponsive. The SM screamed and alerted the Adult



Sister (AS) that the SC was not breathing and appeared purple in color. The AS summoned for emergency medical assistance and she assisted the SM as they administered CPR on the SC until the FD arrived. The SC was pronounced dead at BLH. The two-year-old MU and the twelve-year-old SS were deemed safe in the care of the MGM.

ACS learned from the Dr. that the SC had been born prematurely but was a medically well infant. The ME reported the SC's death would be listed as accidental as there was bed-sharing by the SM who admitted to lying on top of the SC. The Specialist had not observed the SM's bedroom, but was provided photographs by LE. LE reported the home was described as clean and safe with appropriate sleep accommodations for all family members except the MU with whom the AS (his BM) would bed-share. After counseling the SM on safe sleep, ACS provided a bed for the MU. LE reported they found no criminality in their investigation and closed their case without pursuing any criminal charges against the SM.

On 11/18/18, the Specialist interviewed the SM who stated she had not received safe sleep instruction and she had always bed-shared with her children. She had no current relationship with the BF who was not involved in the SC's life. On 11/18, the Specialist interviewed the SS and Adult Brother (AB) who reported they were asleep until they were awoken by the FD. The twelve-year-old SS received counseling in school in response to the fatality and was doing well. ACS counseled the AS about bed-sharing with her two-year-old child. The SM and SS enrolled in family bereavement counseling, under the auspices of Children's Village, to address concerns regarding the fatal incident.

On 11/19/18, the Specialist interviewed the BF who reported he and the SM's one year relationship ended and he no concerns regarding the care the SM gave to the SC. He added that he had never seen her intoxicated.

According to ACS' case documentation, the AS and AB had relocated and the SM was looking for another residence.

On 2/8/19, ACS unsubstantiated the DOA/Fatality and IG allegations of the 11/17/18 report. However, it appears there was some credible evidence to support the substantiation of the IG allegation. ACS did not consider the SM's documented alcohol consumption prior to bed-sharing with the SC which placed the SC at risk. Although LE and the ME found no criminality, the CPS standard of "Some credible evidence," appears to have been met.

Official Manner and Cause of Death

Official Manner: Pending

Primary Cause of Death: Unknown

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No

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

Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048428 - Deceased Child, Female, 1 Mons	048429 - Mother, Female, 43 Year(s)	Inadequate Guardianship	Unsubstantiated
048428 - Deceased Child, Female, 1 Mons	048429 - Mother, Female, 43 Year(s)	DOA / Fatality	Unsubstantiated



CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

Information was entered in a timely manner.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



harm, were the safety interventions, including parent/caretaker actions adequate?				
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Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain:
The SS received counseling in school and the SM along with the AS accepted PPRS.

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain as necessary:
The surviving children who resided in the home were deemed safe in the care of the SM.

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:

The MU was assessed for daycare services, though it was not evident whether services were used.

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:

The twelve-year-old SS received counseling at school in regards to the fatality. The SM and the AS engaged in services; however, the AB declined ACS' offers to provide services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:

The SM and AS engaged in bereavement counseling.

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

The SM was known to the SCR and ACS as the subject in six reports dating from 1/15/08 through 7/06/14. One report was a duplicate of the other and investigated alongside of the initial report, four were unfounded and one was indicated. The reoccurring theme of the unfounded reports were PD/AM and IG. The indicated 1/15/08 report alleged EdN of the now adult sibling by the SM.

Known CPS History Outside of NYS

There is 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

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