NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-064 **Prepared by: New York City Regional Office**

Issue Date: 12/19/2016

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 06/27/2016
Initial Date OCFS Notified: 06/27/2016

Presenting Information

The 6/27/16, SCR report alleged the father suffocated the 2-month-old while in the bassinet. The father told his friends that he put the pillow over the child's face because he would not stop crying. The police responded to the home and the father reported he did not know what happened as he just put the child on his stomach. It was unknown if the mother was home at the time.

On the same date, a subsequent report alleged the 2-month-old was in the care of the parents. The mother fed the child around 5:00 AM and laid him down to sleep in a bassinet. The mother checked the child around 7:00 AM and the child was found to be unresponsive and unconscious. The child was transported to the Kings County Hospital where he was pronounced dead. The child was an otherwise healthy child without any health concerns or conditions. The roles of the MGM and 1-year-old were unknown. It was unknown if the mother was home at the time.

Executive Summary

This 2-month-old SC died on 6/27/16. The allegations of the 6/27/16 SCR reports were DOA/Fatality, IG, of the SC by the birth parents (BP's) as well as allegations of IG and PD/AM of the surviving sibling (SS) by the parents and MGM.

The ME listed the cause and manner of SC’s death as undetermined.

According to the record, the parents were the only adults in the home and were the sole caretakers of the SC and the SS prior to the SC having been found unresponsive on 6/27/16. Prior to the incident, at approximately 3:00 AM and again around 4:45 AM the SM went into the living room to feed the SC formula. The SM placed the SC in the bassinet face down to sleep each time. The SM observed no change in the SC’s health at either feeding. At approximately 7:00 AM, the SM checked the SC in the living room and observed the SC was cyanotic and unresponsive. The SM alerted the SF, who was asleep on the sofa next to the SC's bassinet. The parents called 911. Upon EMS’ arrival the SC was intubated and was transported with the BPs and the SS to the hospital; where the SC was pronounced dead at 7:53 AM.

The SC resided in a one bedroom apartment with the BPs, SS and MGM. The MGM was not at home at the time of the incident. According to the SM, the SC had no pre-existing health condition and presented no signs of illness before death. The parents admitted they received safe sleep education from Brooklyn Hospital prior to SC’s discharge after birth and continued to place the SC face down in the bassinet to sleep on top of two adult sized pillows against the MGM’s advice. ACS did not attempt to ascertain if there was any drug or alcohol use at the time of the incident.

The BP's agreed to accept PPRS services and the Family Services Stage (FSS) was opened on 6/30/16. ACS conducted joint home visit (JHV) with CAMBA/Safe Care CP on 7/14/16. The initial FASP was due on 7/30/16; however, the FASP was approved on 8/17/16 and an explanation was not provided.

On 8/26/16, ACS unsubstantiated the allegation of DOA/Fatality of the SC by the BPs based on what ACS determined to be the ME's inability to provide a definitive cause and manner of death; the cause and manner was listed as undetermined. The allegation of IG of the SC by the BPs was substantiated. The allegation of PD/AM of the SS by the SF was unsubstantiated on the basis there was no credible evidence the SF cared for the SS while under the influence of marijuana. ACS added the MGM to the report and substantiated the allegation of IG against her. ACS documented the MGM who failed to intervene although case notes indicated the MGM advised the BPs to cease the practice of placing the SC in a prone position in the bassinet. ACS' decision to substantiate the allegation of IG for the SS by the BP's and MGM was contradictory with the narrative description in the investigation conclusion.

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:
The casework activity did not include contact with the first responders, attending physicians or the use of the EMS liaison to obtain the EMS log information.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	A significant number of progress notes were observed with entry dates 30 days after the event date.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff

	involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Pre-Determination/Supervisor Review
Summary:	The decisions made pertaining to all the allegations by the parents and MGM were not clearly stated in the Supervisor review.
Legal Reference:	18 NYCRR 432.2(b)(3)(v)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Required data and official documents
Summary:	The SF did not reside full time in the home. There was no further PA database clearance for SF's or inquiry regarding the SF's residence and if children resided at that residence.
Legal Reference:	428.3(b)(2)(i)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Timeliness of completion of FASP
Summary:	The initial FASP was due on 7/30/16 however, the FASP was approved on 8/17/16.
Legal Reference:	18 NYCRR 428.3(f)(5)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	The SF admitted to drug use history and tested positive for a drug. ACS did not explore SF's drug use pattern and the supervision of SC and SS or obtain the SF's address to investigate contacts or assess possible children at that residence.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Appropriateness of allegation determination
Summary:	There was credible evidence to substantiate the DOA/Fatality allegation as the parents admitted they received safe sleep education and routinely placed the SC to sleep face down on top of two adult pillows against the MGM advisement.

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 the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Predetermination/Assessment of Current Safety and Risk
Summary:	The risk assessment had an incorrect selection regarding the age of the children at the time of the fatality. There was no financial assessment follow-up regarding the family's rent arrears, possible eviction and the SF's domestic incident history.
Legal Reference:	18 NYCRR 432.1(aa)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There was no documentation or diligent efforts made by ACS to contact the first responders or the ER staff who administered treatment to the SC on 6/27/16.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/27/2016 **Time of Death:** 07:53 AM

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

County where fatality incident occurred: KINGS
Was 911 or local emergency number called? Yes
Time of Call: 07:19 AM
Did EMS to 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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	51 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	15 Month(s)
Other Household 1	Other Child	No Role	Male	4 Year(s)
Other Household 1	Other Child	No Role	Male	1 Year(s)

LDSS Response

According to LE, a call to 911 was made at 7:19 AM on 6/27/16 regarding the unconscious SC. EMS responded to the home and found the SC unresponsive. It was unclear who made the call. There were no signs of trauma observed on the SC's body. The SC was intubated and then transported to the hospital where the SC was pronounced dead at 7:53 AM. The ME conducted a re-enactment with the SM. LE took photos. The two pillows found in the bassinette were taken into evidence. LE stated the SC's death was not suspicious and no arrests were made.

On 6/27/16, the ME stated the autopsy results were pending further toxicology studies. No trauma was observed to the SC's body.

The SM stated the SC was healthy and no change was observed. The SM stated the SC was fed and placed to bed around 3:00 AM on 6/27/16. The SC woke up around 4:45 AM for another feeding. The SM was placed face down, as usual, in the bassinet to sleep. At approximately 7:00 AM, The SM checked on the SC and noticed the SC was a blue color. The SM acknowledged the MGM routinely stated the SC should have been placed on the back to sleep.

During the 6/28/16 interview of the SF, he stated he did not reside in the home full time. ACS noted some inconsistencies existed in the parent's statement regarding the timeframes and how many feedings the SC received prior to finding the SC unresponsive. The parents confirmed the SC was always placed to sleep in a bassinet; face down on top of two large pillows, as common practice when the SS was an infant.

According to the MGM, she observed the SF holding the SC in the living room around 3:00 AM. The MGM did not notice

a change in the SC. The MGM said she had not seen the SC in the bassinet before she left the home but she believed the SC was fine since she saw SC awake one hour prior. The MGM admitted she consistently advised the parents to place SC to sleep on his back.

ACS conducted a home visit to assess the SS for safety and sleeping arrangements. The SC resided in a one bedroom apartment with the parents, SS and MGM. The apartment had a secured balcony. The Specialist observed adequate provisions for the SS. The bedroom had two full size beds that belonged to the parents and the other to the MGM. Several bags filled with clothing alongside MGM's bed were observed. The bags were not accessible to the SS and did not pose a danger. The SC's bassinet was observed in the living room free of stains. There were safety concerns observed. The household contained one uninstalled smoke/carbon detector that lacked batteries and the SS co-slept with the parents. ACS provided batteries and a pack and play for the parents.

On 7/12/16, an Initial Child Safety Conference (ICSC) was held with the parents and SS. The safety concerns of the SS's sleeping arrangement and his missed medical appointments were discussed. Due to the concerns and the vulnerability of the SS's safety, ACS requested court ordered supervision (COS).

On 7/13/16, ACS attempted file a petition against the parents and to release the SS under COS to the parents. However, FCLS assessed there was not sufficient information to sustain a cause of action as the evidence presented by ACS indicated the SC died of accidental causes and there was not a sufficient basis to file a derivative case as to the SS.

On 7/14/16, ACS conducted a JHV with PPRS CAMBA Safe Care. The parents agreed to drug screening. The SF admitted he smoked marijuana the day before the incident. The SF denied he smoked in front of the children or was under the influence as caretaker of the children. The parents were referred for drug screening on 7/19/16. Both failed to appear.

On 7/20/16, the PPRS CP made a home visit (HV) and had no safety concerns regarding the SS. On 8/18/16, the SM test result was negative while the SF's result was positive for marijuana. The SF was referred to New Directions. It was unclear if SF attended the 8/25/16 intake appointment.

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
Comments: The investigation adhered to previously approved protocols for joint investigation.

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
029461 - Deceased Child, Male, 2 Mons	029463 - Father, Male, 22 Year(s)	Inadequate Guardianship	Substantiated
029461 - Deceased Child, Male, 2 Mons	033221 - Grandparent, Female, 51 Year(s)	Inadequate Guardianship	Substantiated
029461 - Deceased Child, Male, 2 Mons	029462 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
029461 - Deceased Child, Male, 2 Mons	029463 - Father, Male, 22 Year(s)	DOA / Fatality	Unsubstantiated
029461 - Deceased Child, Male, 2 Mons	029462 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
029465 - Sibling, Male, 15 Month(s)	029462 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
029465 - Sibling, Male, 15 Month(s)	033221 - Grandparent, Female, 51 Year(s)	Inadequate Guardianship	Substantiated
029465 - Sibling, Male, 15 Month(s)	029463 - Father, Male, 22 Year(s)	Inadequate Guardianship	Substantiated
029465 - Sibling, Male, 15 Month(s)	029463 - Father, Male, 22 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint	☒	☐	☐	☐

investigation?				
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:
There was no documentation or diligent efforts for by ACS to contact the first responders or the ER staff that performed treatment on the SC on 6/27/16.

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:
The safety factor comment was contradictory to the progress note that stated the bags alongside the MGM bed were not hazardous to the siblings. The 7-Day assessment was a replica of the 24-Hour safety Assessment. The 30-Day assessment contained selected safety factors that were resolved during the investigation.

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

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	Needed but not Offered	Needed but Unavaliable	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	☐	☐	☐	☐	☐	☒	☐

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 parents had no CPS history more than three years prior to the fatality.

The MGM residing in the home was known to the SCR. The 12/14/07 report alleged IG of the SM by the MGM. The allegation was unsubstantiated on 2/15/08.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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