Child Fatality Report

Report Identification Number: AL-17-012

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

Issue Date: Sep 21, 2017

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		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Clinton
Gender: Male
Date of Death: 04/01/2017
Initial Date OCFS Notified: 04/03/2017

Presenting Information

On 4/1/17 between 5:30-5:40 am the SM fed SC (twin A) a bottle, held him upright for about 30 minutes and then propped him on a pillow on her bed while she fed the SS (twin B). The SM reported that after propping the SC and Twin B near each other on the bed, the SM later had lain them flat at around 7:15 am. At approximately 7:30 am the SM noticed that the SC was pale and limp with blood running out of his nose. The SM called the SF and then called 911. The SM initiated CPR while on the phone with 911. The SC was brought to the Health Network where he was revived and intubated prior to being transported to another Medical facility. The SC was admitted to the NICU where life-saving efforts continued until his death at 7:32 pm on 4/1/2017.

Executive Summary

CCDSS first learned of the SC via an SCR report received on 4/1/2017, that alleged IG and II against the SF and the SM for the SC. Twin B and the SS (age 3) were listed with no role. The SC died later that same day at 7:32 pm and this additional information was sent to CCDSS from the SCR. There were no additional allegations. On 4/3/2017, CCDSS notified the OCFS Albany regional office of the SC passing through form 7065.

Upon receipt of the report, a joint investigation was conducted by CCDSS and LE. CCDSS initiated an immediate investigation which included contact with the source and all other required contacts. SCR and criminal history checks were completed and reviewed. Both the SM and the SF had no known history of drug or alcohol misuse.

CCDSS assessed the safety of Twin B and the SS (age 3). CCDSS offered the family bereavement counseling and other services as needed. The investigation included appropriate case and collateral contacts including but not limited to medical providers, LE and other appropriate collaterals able to provide information on the safety of the SSs. There were some parental care concerns noted during the investigation. It was learned through interviews and medical records that the SC was born at 31 weeks gestation. The SC and Twin B had multiple medical issues related to their premature birth and remained hospitalized for an extended period of time. The SC was released prior to Twin B on 2/15/2017. The SC was re-hospitalized on 2/19/2017. The SC aspirated as a result of being fed via a propped bottle and placed in an infant car seat. The SF and the SM had been told by the pediatrician and the hospital staff prior to discharging the infant home not to bottle prop while feeding the SC due to his gastrointestional/reflux and to have SC remain upright for approximately 30 minutes after feeding. It was also learned that the SM and the SF were co-sleeping with the twins on a regular basis as SM admitted this to LE. The SM and the SF had been informed about safe sleep practice by their pediatrician and this was clearly documented in the records provided. CCDSS appropriately addressed these concerns by making sure the SM and the SF purchased a bassinet for Twin B and ensuring that Twin B slept in the bassinet with an oximeter and baby monitor that remained on. From the time of the receipt of the report CCDSS had frequent contact with the SF, the SM, the Twin B and the SS (age 3) in the home. There were no arrests made.

An autopsy was performed on 4/3/17. The preliminary autopsy revealed no signs of abuse or maltreatment; the final autopsy results were pending at the time of the writing of this report. CCDSS appropriately Sub the allegation of IG against the SF and the SM for the SC and Unsub the allegation of II against the SF and the SM for the SC. The SF and the SM failed to provide a minimum degree of care by placing the SC in imminent danger by feeding the SC via a propped bottle and failing to ensure he remain upright after feeding as directed by their pediatrician due to the SC's previously diagnosed medical issues. There was no credible evidence to substantiate the II allegation against the SM and the SF about

the SC based on conversations that CCDSS had with the ME. The report was IND and closed. The family was referred to community based services.

The OCFS review of the history resulted in a casework practice citation. LDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) the LDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, LDSS will review the plan(s) and revise as needed to further 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?** 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?** Yes

Explain:
CCDSS did fully explore the safety and risk of the SS. CCDSS offered and provided services until the closing of the case.

Was the decision to close the case appropriate? Yes

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 SM and the SF addressed the safe sleep concerns by purchasing a bassinet that was placed in their bedroom. The SS (twin B) continued to sleep alone in the bassinet with a pulse oximeter and a baby monitor that remained on at all times. There were no safety concerns regarding the SS (age 3).

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: 04/01/2017 **Time of Death:** 07:32 PM

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

County where fatality incident occurred: Clinton
Was 911 or local emergency number called? Yes
Time of Call: 07:32 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
Adults: 0

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	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Month(s)

LDSS Response

CCDSS began their investigation on 4/1/2017, by contacting the source of the report and LE. CCDSS submitted a 7065 on 4/3/2017 as required. Through interviews with the SF and the SM, LE, ME, observations of the home/sleeping environment and review of all medical records that were provided the following information was learned. On the morning of 4/1/2017, the SM woke up to find the SC unresponsive and not breathing on his back in the SM and SF's bed. The SC and Twin B were placed side by side at the top of the bed propped on pillows as reported by SM. The SM called the SF who was on his way home from working overnight, and he advised the SM to call 911. The SM called 911 and was instructed to perform CPR and they provided her with instructions. The SM stated she put SC on the floor to perform CPR.

EMS transported the SC to a medical facility where he was stabilized and transferred to another medical facility. The SC went into multi-organ failure do to prolonged CPR and died later that evening.

Further investigation revealed that the SC and Twin B were co-sleeping regularly with the SM and the SF. The co-sleeping was occurring despite having been previously educated on the risks of co-sleeping by both CPS and the pediatrician. It was also noted in the medical documents provided by the pediatrician that the SM had been telling the pediatrician that the SC and Twin B were sleeping in bassinets. When CCDSS went to the home it was learned that the family did not own bassinets and the SC and Twin B cribs were in another room. The SF and the SM had been instructed by the pediatrician on numerous occasions that the SC needed to remain upright after feeding for at least 30 minutes due to his medical condition. The SM provided multiple explanations of the events of that morning, initially stating that she was awake and going between her room, the twins' room and the SS (age 3) room; later the SM stated she had fed both the SC and Twin B. The SM then stated she held the SC upright for the directed amount of time. The SM then stated she propped both chn on pillows near her before laying them down flat on the bed.

Several weeks prior to the 4/1/2017 incident, the SC was re-hospitalized after he aspirated while being fed via a propped bottled while in an infant car seat. After listening to the 911 call from the 4/1/2017 reported incident, it was learned the SM was co-sleeping with the SC and Twin B the night of the incident.

Based on above information the SF and the SM were advised by CCDSS to buy a bassinet for the Twin B or move the crib for Twin B into their bedroom. The SF and the SM did buy a bassinet and placed Twin B in the bassinet to sleep with a pulse oximeter and baby monitor on all the time. The SS (age 3) safety was assessed and there were no safety concerns. CCDSS continued to meet with the SF, the SM, and to observe Twin B and the SS (age 3). CCDSS appropriately addressed the previously reported IND case with the family. There were no other safety concerns.

CCDSS appropriately Sub the allegation of IG against the SF and the SM for the SC. The SF and the SM had an established pattern of behavior of co-sleeping and bottle propping when feeding the SC, even after instructed not to do so. The SF and the SM failed to provide a minimum degree of care because of their pattern of behavior in which the parents failed to follow through with prescribed treatment for the SC medical condition. The SC had previously been admitted to the hospital for a similar incident just weeks before the reported incident. The allegation of II against the SF and the SM was Usub based on review of medical documentation and interviews with medical staff and providers. The report was IND and closed. The family was referred to community based services.

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 reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: CCDSS has an approved OCFS Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine

All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
CCDSS completed adequate safety and risk assessments, implemented safety plans when necessary and gathered sufficient information to make a determination. Services needs were adequately assessed, offered and put in place when necessary.

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:
This was an open CPS investigation and there was no DOA/Fatality allegation. Therefore, no 24 hour report or 30 day report was required. CCDSS did appropriately assess the safety of the SS's in the case record within 24 hours and a 7 day safety assessment was completed.

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: No children were removed as a result of the report.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Preventive services							

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:
CCDSS made recommendations and offered services to the SF and the SM to promote the safety and well being of the Twin B. On recommendations of CCDSS the SF and the SM purchased a bassinet for the Twin B. The Twin B was now sleeping alone in the bassinet with a pulse oximeter and a baby monitor which remained on at all times. Due to Twin B medical needs this plan was needed and implemented to promote the safety of the Twin B.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
CCDSS offered referrals to bereavement services to the family. CCDSS offered assistance with funeral arrangements and provided a list of funeral homes. CCDSS reviewed safe sleep with the SF and the SM and an packet was provided. CCDSS appropriately addressed a previously IND report and offered domestic violence services.

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

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

☒ Was not noted in the case record to have any of the issues listed

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/01/2017	Deceased Child, Male, 2 Months	Mother, Female, 24 Years	Internal Injuries	Unfounded	No
	Deceased Child, Male, 2 Months	Father, Male, 25 Years	Internal Injuries	Unfounded	
	Deceased Child, Male, 2 Months	Mother, Female, 24 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 2 Months	Father, Male, 25 Years	Inadequate Guardianship	Indicated	

Report Summary:
On 4/01/2017 an SCR report was received alleging IG and II against the SF and the SM for the SC. The SC was found unresponsive at about 7:30 am and the SM called 911. EMS brought the SC to the hospital in cardiac arrest and SC was intubated and placed on a ventilator and listed in critical condition. The SC was later transferred to another hospital and subsequently died and Additional information about the death was taken by the SCR and sent to CCDSS.

Determination: Indicated | **Date of Determination:** 05/30/2017

Basis for Determination:
CCDSS Sub the allegation of IG against the SF and the SM for the SC. The SC was born premature and had mutiple medical issues as a result. The SF and the SM had been instructed to hold the SC upright for 30 minutes after feeding due to his medical condition. The Investigation revealed the SM and the SF were co sleeping with the SC on a regular basis. The SM fed the SC, held the SC upright and then propped the SC in the bed. The SF and the SM failed to exercise a minimum degree of care by failing to follow through with prescribed treatment for the SC by placing the SC in immediate danger. The report was IND and closed. The family was referred to community based services.

OCFS Review Results:
OCFS found the investigation to be complete and the determination was appropriate based on the information gathered.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/30/2016	Sibling, Male, 1 Years	Father, Male, 25 Years	Inadequate Guardianship	Indicated	Yes

Report Summary:
On 1/30/2016 an SCR report was received alleging IG against the SF for the SS (age 1). It was reported that the SF physically assaulted the SM while she was holding the SC. The SF shoved, punched and strangled the SM. The SC was not physically injured. The SF was arrested and charged with endangering the welfare of a child, assault 3rd, criminal obstruction of breathing, and criminal mischief 4th.

Determination: Indicated | **Date of Determination:** 03/24/2016

Basis for Determination:
The allegation of IG was SUB against the SF for the SS. The investigation revealed that the SF did assault the SM while she was holding the SS. The SF pushed, hit and strangled the SM. The SF's violent outburst that resulted in a serious threat of injury to the SS. The SF failed to exercise a minimum degree of care which resulted in placing the SS in imminent danger of impairment. The report was IND and closed.

OCFS Review Results:
The OCFS review showed the 7 day safety assessment was not completed on time and was 29 days overdue. There was no secondary caretaker identified on the RAP. The SF should have been including in the family Risk Assessment Profile. CCDSS failed to contact the criminal court to verify that the criminal charges had been dropped and the OOP was vacated before closing the report.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
CCDSS failed to complete the 7 day safety assessment on time. Safety assessment was 29 days overdue.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
CCDSS will complete the 7 day safety assessment within 7 days of receipt of a report.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
There was no secondary caretaker was identified in the Risk Assessment Profile, when it was known that SF had a regular care taking role for the SS.
Legal Reference:
18 NYCRR 432.2(d)
Action:
CCDSS will accurately reflect the current caretakers of children in risk assessments, and accurately assess and document each respective risk element identified into the Risk Assessment Profile. Furthermore, CCDSS identified risk factors for the SF that would have been pertinent to record as it pertained to the SS.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
CCDSS had information that the OP that protected the SS had changed, but failed to verify this with an appropriate collateral contact prior to the determination safety assessment.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
CCDSS will contact all appropriate collaterals during an investigation.

[redacted]

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

There was no history.

Known CPS History Outside of NYS

There is no known 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.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement 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?
☐Family Court ☒Criminal Court ☒Order of Protection

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
01/30/2016	SF	Unknown	BM reported charges were dropped
Comments:	On 1/30/2016 the SF was arrested on numerous charges and an full stay away order was issued. However, BM told CCDSS in a phone conversation on 3/24/2016 that all charges were dropped and SF was allowed to return home.		

Have any Orders of Protection been issued? Yes	
From: 01/30/2016	**To:** Unknown

Explain:
A criminal court OOP a full stay away order was issued about an incident reported to LE and the SCR on 1/30/2016. The BM told CCDSS in a phone conversation that all the criminal charges against her husband were dropped and the SF was allowed to return home. There is no documentation in the file by CCDSS that this was ever verified with criminal court.

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