Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-18-020

Prepared by: New York City Regional Office

Issue Date: Aug 24, 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: 1 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 02/24/2018
Initial Date OCFS Notified: 02/24/2018

Presenting Information

The SCR registered a report alleging the mother went to sleep with the 1-month old SC on her chest on 2/23/18. The report alleged the mother found the SC unresponsive and face down next to the mother on 2/24/18. The report stated the mother called 911 and the SC was pronounced dead. The report added there was formula in the SC's throat and the SC had no pre-existing medical condition.

According to the report, the father did not reside in the home and it was unknown whether he was in the home at the time of the incident. The role of the father and siblings were unknown.

Executive Summary

The SC was 1-month-old when he died on 2/24/18. The autopsy revealed the cause of death was due to positional asphyxia (infant found prone in soft bedding while co-sleeping with adult in adult bed) and the manner of death was ruled accidental.

The SC resided with the mother and three siblings. The father resided out of the home, but visited the children and provided financial support for the family. The father of the 12-year-old sibling was not involved in her life.

On 2/24/18, the SCR registered a report concerning the death of the SC. The allegations of the report were DOA/FATL and IG of the SC by the mother. ACS added allegations of LMC and IG of the siblings by the parents.

According to the mother, on 2/24/18, she fed the SC sometime between 12:00 A.M. and 1:00 A.M. and then laid back on her full-size bed to burp him. The mother said she fell asleep and when she awoke at approximately 6:30 A.M., the SC was lying next to her face down and unresponsive. The mother said she called 911 and EMS transported the SC and the family to the hospital. The 12-year-old sibling corroborated the mother's account. The 8-year-old sibling refused to be interviewed.

On 2/24/18 and 2/27/18, the siblings were assessed by ACS and the Child Advocacy Center (CAC) and they had no signs of marks or bruises; however, the home was assessed to be unsafe and the family relocated to another apartment.

ACS interviewed the medical staff at Coney Island Hospital and learned there were no indications of abuse or maltreatment of the SC. The NYPD told ACS there was no suspicion of foul play concerning the death of the SC.

On 3/6/18, as per ACS protocol, ACS held two Child Safety Conferences (CSC) to meet with the parents individually due to the SC's death and past DV history. ACS determined court intervention was required. Family Court Legal Services (FCLS) reviewed the case and determined there was insufficient information to name the father a respondent. On 3/8/18, ACS filed an Article 10 Neglect Petition at the Kings County Family Court (KCFC) naming the mother as the respondent. The KCFC released the siblings to the mother with court ordered supervision (COS). The family was referred to Jewish Board Children and Family Services (JBCFS) for PPRS; the mother signed the application for services on 6/1/18.

On 7/13/18, the mother left the siblings with the father and said she could no longer care for the siblings.

On 7/18/18, ACS filed an order to show cause to vacate the prior court order concerning the release of the siblings to the

respondent mother and temporarily released the siblings to the non-respondent father with COS due to a change in circumstance. The non-respondent father was expected to submit to the jurisdiction of the court, including ACS supervision.

ACS initiated this investigation timely. However; ACS did not properly assess the family's current functioning or dynamics. This impacted negatively on their ability to properly complete safety and risk assessments.

Progress notes were not clear and concise and several were not entered contemporaneously.

ACS made some relevant and reasonable referrals for the family. However; when in regards to the father, ACS dictated conditions at different intervals that were not court ordered nor relevant to case circumstances.

ACS learned of the parents' DV history and focused most of their case activities and service planning on this issue but there were no assessments of power or control issues in the parents' current relationship.

ACS made diligent efforts and located the 12-year-old sibling's father. However, he showed no interest in planning for his child.

On 8/16/18, ACS substantiated the allegations against the parents. However, did not provide an adequate narrative to support the allegations of LMC by the parents or IG against the father.

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?**	No, sufficient information was gathered to determine some allegations only.
• **Was the determination made by the district to unfound or indicate appropriate?**	Yes
Was the decision to close the case appropriate?	N/A
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?	No
Was there sufficient documentation of supervisory consultation?	Yes, the case record has detail of the consultation.

Explain:
The family was referred for PPRS and is under Family Court ordered supervision.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS selected a safety decision stating the children were in immediate danger of serious harm, but documented the contrary in the progress notes. The comments for the selected safety factors did not reflect the family's current circumstances.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	ACS did not complete the safety assessment based on the current case circumstances.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	ACS did not complete the safety assessment based on the current case circumstances.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Progress Notes
Summary:	Progress notes were not entered contemporaneously, some were not clear and concise.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	Throughout the investigation ACS did not consider the information gathered to assess the family's strengths and did not explore with the children the past/present issues of DV.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Risk Assessment Profile (RAP)

Summary:	The RAP was not completed properly as responses to several questions were not completed properly and/or explored. The RAP was completed prematurely and did not capture all the information gathered from the entire investigation.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	ACS selected an appropriate safety decision. However, did not select all current safety factors relevant to this family's circumstances. The documentation in this assessment was convoluted.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	ACS substantiated all the allegations of the report, but did not provide a narrative that supported the determination of each allegation as it pertained to each subject.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/24/2018 **Time of Death:** 07:40 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 06:30 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? 5 Hours

Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were 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	1 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	12 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	37 Year(s)

LDSS Response

On 2/24/18, ACS visited the case address and observed a crib for the SC, two twin size beds for the older siblings, and a full-sized bed the mother shared with the 2-year-old sibling. The mother told ACS she received safe sleep information but still co-slept with the SC and the 2-year-old sibling. ACS determined the home was unsafe as the furniture blocked the windows and it was heated by a space heater. The mother reported she was tired and overwhelmed with caring for the children.

The mother said she fell asleep while she was burping the SC and when she awoke the SC was lying in between her and the 2-year-old sibling. The mother described the SC as lying face down, cold and unresponsive.

The 12-year-old sibling told ACS that at about 1:23 A.M., she went to sleep. At that time, the mother was burping the SC on her chest and the 2-year-old sibling was on the bed ready to sleep. The 12-year-old sibling said she woke up when she heard the mother screaming and asking for help as the SC was unresponsive. The 12-year-old sibling said she called 911 and the operator instructed her to administer CPR. The 12-year-old sibling said she placed the SC on a table and breathed in the SC's mouth. The sibling said the SC felt cold and when she pressed on his chest she saw blood coming out of his mouth. The sibling said she wiped the blood and continued CPR, but could not save the SC.

On 2/26/18, ACS interviewed the landlord (LL) who said the mother was not a good parent, he elaborated by saying she liked to drink and "party." The landlord also said he knew the father for several years and described him as a good parent and provider. The LL showed ACS a video that revealed that on 2/24/18 at 6:36 A.M., when EMS arrived at the case address, the mother was seen throwing a white bag out the door before the police arrived. ACS observed the NYPD exit the home and when EMS exited the apartment with the infant the mother picked up the white garbage bag and threw it into the trash before she got into the ambulance. The LL pointed to the bag and said he believed the bag was full of empty beer bottles and this was not unusual. The LL said he was aware of DV between the parents but blamed the mother for the incidents because she would stay out all night drinking. The landlord's wife said that on 2/23/18, she heard a scream from the home and loud music.

On 3/5/18, ACS held separate CSCs due to the parents' DV history. According to the father, he was in the home from 2/18/18 through 6:00 A.M. on 2/23/18. The father said the mother kicked him out after they argued on 2/22/18 about the

children for an unspecified reason. The father said he blamed the mother for the death of the SC because she had been "drinking alcohol beverages." The father said when the mother drank alcohol she would become a "different person," who would become angry and insulting. The father admitted to drinking occasionally at social events and reported he wanted full custody of the children. The father confirmed he had filed a custody petition. The father admitted he and the mother had a DV history but alleged she was the aggressor.

ACS contacted the children's school and medical providers and there were no concerns about the mother's ability to attend to the educational and medical needs of the children.

In July 2018, the mother left the children in the care of the father. ACS assessed the siblings to be safe in his care and they were released to the father with Family Court ordered supervision. The mother was granted supervised visitation.

On 8/16/18, ACS substantiated the allegations of the report the report.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
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
046621 - Deceased Child, Male, 1 Mons	046820 - Father, Male, 37 Year(s)	Lack of Medical Care	Substantiated
046621 - Deceased Child, Male, 1 Mons	046820 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
046621 - Deceased Child, Male, 1 Mons	046622 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
046621 - Deceased Child, Male, 1 Mons	046622 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
046621 - Deceased Child, Male, 1 Mons	046622 - Mother, Female, 30 Year(s)	Lack of Medical Care	Substantiated
046817 - Sibling, Female, 12 Year(s)	046820 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
046817 - Sibling, Female, 12 Year(s)	046622 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
046818 - Sibling, Male, 8 Year(s)	046622 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated

046818 - Sibling, Male, 8 Year(s)	046820 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
046819 - Sibling, Female, 2 Year(s)	046622 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
046819 - Sibling, Female, 2 Year(s)	046622 - Mother, Female, 30 Year(s)	Lack of Medical Care	Substantiated
046819 - Sibling, Female, 2 Year(s)	046820 - Father, Male, 37 Year(s)	Lack of Medical Care	Substantiated
046819 - Sibling, Female, 2 Year(s)	046820 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated

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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☐	☒	☐	☐

Additional information:

ACS did not conduct a crime scene investigation as they were not allowed access to the home immediately after the investigation.

Some progress notes were not entered contemporaneously.

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 completion of the safety assessments were not consistent with the case circumstances at the different intervals. The comments to support the safety factors were not clear or concise. In addition, the safety assessments did not provide an accurate assessment of the parents' ability and/or willingness to care for the children.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/08/2018	There was not a fact finding	There was not a disposition
Respondent:	046622 Mother Female 30 Year(s)	
Comments:	On 7/18/18, there was an order to show cause in this case and the siblings were temporarily released to the father with COS.	

Family Court Petition Type: Other Family Court (Including Article 6 Custody/Guardianship		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/26/2018	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	After the SC's death, the father filed for custody of his two children, the 2-and 8-year-old siblings. The petition remained pending at the time of this writing.	

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	☐	☐	☐	☐	☐	☒	☐

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? N/A
Explain:
No immediate services were offered or needed. Later during the investigation, the family was referred for PPRS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
No immediate services offered or needed. Later in the investigation the family was referred for PPRS.

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 mother was named as a subject in nine reports; four reports were indicated and five were unfounded. The father was named as a subject in three indicated reports. The allegations of the reports were: PD/AM, LS, L/B/W and IG.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Preventive Services History

The family had a family service case from 4/28/09 – 6/9/10, they were referred by ACS to the HeartShare Family Services agency for PPRS due to concerns involving the mother's unaddressed alcohol abuse and DV. During the time, the family received PPRS there was no emphasis on these issues and the visits with the family were sporadic. The PPRS caseworker discussed the need for Early intervention for the 4-month-old sibling and a speech evaluation for the 4-year-old sibling, but there was no referral or advocacy for these services. The mother requested day care services but there was no follow up concerning this matter. The PPRS case was closed due to the family's non-compliance.

The family also had a family service case from 8/13/12 – 11/13/14. The family was referred by ACS to Mercy First because of DV in the home. The mother received services from Family Justice Center in regards to the DV and immigration status. The mother moved out of the home with the siblings and the agency assisted the mother with applying for public assistance and food stamps. Case documentation reflects the siblings attended school on a regular basis and there were no concerns noted. The PPRS case was closed 11/13/14 because the family met their family service goals.

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