Office of Children and Family Services

# Child Fatality Report

## Report Identification Number: SY-20-026

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

## Issue Date: Nov 24, 2020

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 | ASTO-Allowing Sex Abuse to Occur | |

# Child Fatality Report

## Case Information

**Report Type:** Child Deceased
**Age:** 7 month(s)
**Jurisdiction:** Chenango
**Gender:** Male
**Date of Death:** 06/19/2020
**Initial Date OCFS Notified:** 06/23/2020

### Presenting Information

An SCR report was received that alleged on 6/19/20, the seven-month-old subject child was co-sleeping with his father in his bed and suffocated on a pillow as a result. The father contacted emergency services after noticing the child was unresponsive. The role of the mother was unknown.

### Executive Summary

This fatality report concerns the death of a seven-month-old male subject child that occurred on 6/19/20. A report was made to the SCR on 6/23/20 with allegations of Inadequate Guardianship and DOA/Fatality against the child's father. Chenango County Department of Social Services (CCDSS) received the report and completed a thorough investigation into the child's death. An autopsy was completed, and the final cause and manner of death were undetermined; however, the medical examiner noted the death of the child, "to a reasonable degree of medical certainty, [was] ascribed to sudden death associated with an unsafe sleep environment." Further findings noted focal pneumonia that could have caused the child to be more susceptible to the effects of an unsafe sleep environment and were considered a contributory condition.

At the time of the child's death, he resided with his father. There were no other children in the household; however, the child had three half-siblings, ages two, three, and 16 years old. The younger siblings resided with their biological father, while the older sibling resided with his biological mother. The subject child's mother was homeless at the time of the child's death. It was discovered that on the night of 6/18/19, the father had placed the child to sleep in bed with him between 7:30 and 9:00PM. The father propped the child up on a Boppy pillow and covered him with a small blanket. The father next awoke at approximately 3:00AM to use the bathtroom, and found the child slumped over the Boppy pillow, unresponsive. The father immediately contacted emergency services, who arrived at the home and transported the child to a nearby hospital where he was pronounced deceased.

From the time the investigation began to the time of its closure, CCDSS met with family members and spoke with pertinent collateral sources. CCDSS offered the family appropriate services in response to the fatality. There were no concerns noted surrounding the safety of the surviving half-siblings. It was determined the father had been educated several times in the past surrounding the risks of an unsafe sleeping environment. CCDSS found evidence the father's actions of placing the child in bed with him contributed to the child's death, and therefore indicated and closed their case.

**PIP Requirement**
CCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. The PIP will identify what action(s) CCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, CCDSS 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 gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving half-siblings.

**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 case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

### 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:** 06/19/2020 **Time of Death:** Unknown

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

**County where fatality incident occurred:** Chenango
**Was 911 or local emergency number called?** Yes
**Time of Call:** 03:35 AM
**Did EMS respond to the scene?** Yes

**At time of incident leading to death, had child used alcohol or drugs?** No

**Child's activity at time of incident:**

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

**Did child have supervision at time of incident leading to death?** Yes

**How long before incident was the child last seen by caretaker?** 6 Hours

**At time of incident supervisor was:**

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ Other:

**Total number of deaths at incident event:**

**Children ages 0-18:** 1

**Adults:** 0

**Household Composition at time of Fatality**

| Household | Relationship | Role | Gender | Age |
|---|---|---|---|---|
| Deceased Child's Household | Deceased Child | Alleged Victim | Male | 7 Month(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 36 Year(s) |
| Other Household 1 | Mother | No Role | Female | 20 Year(s) |
| Other Household 2 | Sibling | No Role | Male | 16 Year(s) |
| Other Household 3 | Sibling | No Role | Male | 3 Year(s) |
| Other Household 3 | Sibling | No Role | Female | 2 Year(s) |

**LDSS Response**

On 6/23/20, CCDSS received the report regarding the death of SC. This report was subsequent to an open CPS investigation received on 11/2/19, which alleged SC was born with a positive toxicology for illicit substances. Upon receipt of the fatality report, CCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. Although SC was the only child in the household, he had 3 surviving half-siblings, and CCDSS worked promptly to assess their safety.

On 6/24/20, CCDSS completed a home visit and interviewed SF and BM. SF explained he and BM had not been living together for approximately three weeks prior to SC's death, and on the night of the incident, he was home alone with SC. SF reported since BM moved out, he and SC would sleep together in his bed. Prior to this, SC slept in a bassinet. SF explained the pediatrician advised him to prop SC's head during sleep, as he had medical conditions, so SF would place SC on a Boppy pillow. SF stated on the evening of 6/18/19, he and SC went to bed sometime between 7:30PM and 9:00PM. He explained he awoke around 3:00AM to use the bathroom, and noticed SC was "flopped over" the side of the Boppy pillow, was blue and had no pulse. SF said he called 911 immediately but did not perform CPR because he knew SC was already dead. SF said SC's medical conditions had recently begun to be monitored by a specialist, and SC had been to one appointment approximately one week before his death; follow-up appointments were scheduled. SF stated he successfully completed a drug treatment program and had not used substances since October 2019. On this same date, BM

was interviewed, and she reported she was homeless and had not been at SF's home on the date of the incident. She explained she and SF were no longer in a relationship as of a few weeks prior, and she was in the process of trying to find housing. She did not express any safety concerns surrounding SF's care of SC, and reported she last used drugs a month ago, but had not used since. The 2 and 3yo SS were also at the home at the time of this visit, and BM explained the SS were residing at their father's until she secured an apartment. The home environment was observed and there were no safety concerns noted. CCDSS attempted to speak with the 2 and 3yo SS; however, they would not engage. Neither child had any visible marks or bruises and were assessed as safe.

On 6/26/20, CCDSS spoke with the CHN's pediatrician. CCDSS confirmed the pediatrician recommended the parents prop SC's head using a Boppy pillow until SC could get in to see a specialist regarding his medical conditions. The pediatrician also informed CCDSS that the parents "no-showed" to the scheduled specialist appointment. Later in the investigation, CCDSS asked SF why SC missed the appointment and he reported he could not get out of work in time. SF stated he had rescheduled it for the week SC died.

On 6/30/20, CCDSS interviewed the 16yo SS. The SS reported SC would always sleep next to SF on a Boppy pillow. He denied any safety concerns in SF's home and was not there the day SC died. He was assessed as safe in the care of his mother.

Throughout the investigation, CCDSS spoke with numerous collateral sources and assessed the safety of the SS on several occasions. LE found no criminality regarding SC's death. On 8/24/20, the 2 and 3yo SS' father was awarded full custody of the 2 CHN, and the 16yo SS remained in the care of his mother. CCDSS offered the family appropriate services in response to the fatality, and SF was engaged in counseling at the close of the investigation. CCDSS found evidence SF placed SC at imminent risk of harm by choosing to co-sleep despite knowing the risks of such. Therefore, the case was indicated and closed.

## Official Manner and Cause of Death

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

## Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?**Yes
**Comments:** This fatality investigation was conducted by the Chenango County MDT.

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?**No
**Comments:** Chenango County does not have an OCFS approved Child Fatality Review Team.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 055162 - Deceased Child, Male, 7 Month(s) | 055381 - Father, Male, 36 Year(s) | DOA / Fatality | Substantiated |
| 055162 - Deceased Child, Male, 7 Month(s) | 055381 - Father, Male, 36 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?** | ☒ | ☐ | ☐ | ☐ |
| **Was there timely entry of progress notes and other required documentation?** | ☒ | ☐ | ☐ | ☐ |

**Additional information:**
CCDSS interviewed the family and appropriate collateral sources. Progress notes and other documentation were completed and entered timely.

**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 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?** | ☐ | ☐ | ☒ | ☐ |

**Fatality Risk Assessment / Risk Assessment Profile**

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **Was the risk assessment/RAP adequate in this case?** | ☒ | ☐ | ☐ | ☐ |
| **During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?** | ☒ | ☐ | ☐ | ☐ |
| **Was there an adequate assessment of the family's need for services?** | ☒ | ☐ | ☐ | ☐ |
| **Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?** | ☐ | ☒ | ☐ | ☐ |
| **Were appropriate/needed services offered in this case** | ☒ | ☐ | ☐ | ☐ |
| **Explain:** CCDSS offered the family appropriate services in response to the SC's death. | | | | |

## 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:** The half-siblings were not removed as a result of this fatality 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 | 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** | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Other, specify:** Prevention Services

**Additional information, if necessary:**
CCDSS provided the parents and other family members with bereavement counseling referrals. SF and BM declined a need for substance abuse treatment. Prevention services were offered but declined. The record did not reflect if family planning was discussed with the parents.

**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 provided the family with referrals for grief counseling.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
CCDSS offered the parents referrals for grief and bereavement services. BM declined; however, SF was engaged with an independent provider at the time of case closure.

## History Prior to the Fatality

### Child Information

**Did the child have a history of alleged child abuse/maltreatment?** 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 ☐ Had heavy alcohol use

☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Was not noted in the case record to have any of the issues listed
☐ 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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 11/02/2019 | Deceased Child, Male, 1 Days | Mother, Female, 20 Years | Parents Drug / Alcohol Misuse | Unsubstantiated | Yes |
| | Deceased Child, Male, 1 Days | Father, Male, 36 Years | Inadequate Guardianship | Unsubstantiated | |

**Report Summary:**
This SCR report was received with concerns SC was born with a positive toxicology for cocaine and barbiturates.

**Report Determination:** Indicated | **Date of Determination:** 08/26/2020

**Basis for Determination:**
CCDSS interviewed BM and SF and learned both engaged in drug use on 10/31/19, the night prior to SC's birth. CCDSS assisted the parents with completing a substance abuse evaluation, and both were recommended to attend treatment. SF was compliant with treatment and discharged successfully; however, BM was discharged due to noncompliance and was still engaged in drug use during her time in treatment. SC suffered no negative effects due to the positive toxicology at birth. SC died while this investigation remained ongoing.

**OCFS Review Results:**
The record did not reflect a completed Plan of Safe Care. There was no documented casework activity from 3/31/2020 until 6/22/2020, after CCDSS was informed SC had died. There were concerns brought to the attention of the CW on 3/11/20 that BM was again using drugs and being discharged from her substance abuse treatment program due to noncompliance. The record did not reflect this was ever addressed with BM or SF prior to SC's death, and the CHN went unseen by CCDSS for nearly three months despite these concerns. Most progress notes were entered several months after their event dates. The safety of the SS was not assessed until 1/8/20.

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

**Issue:**
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

**Summary:**
There was no documented casework activity from 3/31/2020 until 6/22/2020. On 3/11/20, CW learned that BM was again using drugs and being discharged from her treatment program due to noncompliance. The record did not reflect this was ever addressed with BM or SF prior to SC's death, and the CHN went unseen for approximately 3 months despite CCDSS having knowledge of the concerns.

**Legal Reference:**
18 NYCRR 432.1 (o)

**Action:**
Throughout the CPS investigation, CCDSS must facilitate information gathering, analyses of safety factors and the inter-relatedness of risk influences and individual risk elements affecting family functioning.

**Issue:**
Timely/Adequate Case Recording/Progress Notes
**Summary:**
Most progress notes were completed several months after their event dates.
**Legal Reference:**
18 NYCRR 428.5
**Action:**
CCDSS will enter progress notes contemporaneously as events occur.

**Issue:**
Timely/Adequate Seven Day Assessment
**Summary:**
The 7 Day Safety Assessment did not speak to the safety of the SS, nor were any questions asked as to where the SS were when BM and SF were engaging in drug use. The safety of the SS was not assessed until 1/8/20.
**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
**Action:**
Within seven days of receiving a report, CCDSS will conduct a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

[redacted]

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

There was no CPS investigative history more than three years prior to the fatality.

## Known CPS History Outside of NYS

There was 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