Child Fatality Report

Report Identification Number: BU-19-011

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

Issue Date: Jul 09, 2019

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 04/06/2007
Initial Date OCFS Notified: 03/05/2019

Presenting Information

An SCR report received on 3/5/2019 alleged the parents were responsible for the subject child's death, which occurred on an unknown date several years ago. The child's age at the time of his death was not reported, nor were the circumstances of the fatality. It was alleged both parents were responsible for his death, since the cause was unknown and he died while in their care.

The same report alleged the parents were responsible for the death of another one of their children (whose age was also not reported), which occurred sometime after the subject child died. It was reported this child suffocated after the parents put a mattress over her to keep her quiet. It was further alleged the parents kept the children locked in cages, and it was noted the parents were arrested, charged, and incarcerated for the death of this child.

Executive Summary

This fatality report concerns a one-month-old child who died on 4/6/2007. Until the SCR report dated 3/5/2019, the infant's death had not been reported as suspicious of abuse or neglect. The infant was not known to CPS during his short life; however, his family had significant history in the years that followed his death.

Niagara County Department of Social Services (NCDSS) completed a thorough multidisciplinary investigation into the reported deaths. Regarding the subject child, NCDSS gathered a substantial amount of information from the family, police, medical examiner, coroner, district attorney, and hospital. An autopsy was completed in 2007, and NCDSS obtained the death certificate. The manner of death was natural, and the cause was Sudden Infant Death Syndrome. Documentation from police, which detailed their investigation in 2007, revealed information about law enforcement's response and observations over a decade ago. Included in those records were descriptions of the environment in which the child was found unresponsive, interviews with the family, facts from the autopsy, and reasons for their investigation's closure without arrests. When NCDSS concluded the case, all allegations concerning the subject child – made against his mother, father, and paternal grandmother – were unsubstantiated.

Information about the subject child's death was previously documented by NCDSS in a CPS investigation from April to June of 2010; this was their first interaction with the family that followed his death. At that time, law enforcement and NCDSS were actively investigating the death of his 1-year-old sister, who died on 4/8/2010. The matter of the predeceased subject child was introduced while NCDSS was gathering family history, and information was confirmed with collaterals. Upon this first time learning about the subject child and his cause of death, NCDSS did not find reasonable cause to suspect his death was a result of abuse or maltreatment by a caretaker. The facts gathered were appropriately recorded in that investigation's case record.

In contrast, the CPS and criminal investigations pursued in 2010 revealed substantial concern for the parents' care of the siblings. It was thereupon confirmed that the parents were responsible for the sibling's death and prior maltreatment as a result of their negligence, in addition to significant maltreatment of the surviving children. In April of 2010, NCDSS responded with family court action and removed all surviving siblings, then ages 9, 5, 4 and 11 months; a child born later that year was also removed. Both parents were incarcerated for charges regarding the 1-year-old's death.

OCFS issued a fatality report in 2013 concerning the 1-year-old child. In the current investigation, NCDSS carried over pertinent information from past case records and found no new information about her death; such facts remained

unchanged, and this was confirmed with multiple sources. Once again, NCDSS appropriately substantiated the fatality-related allegations against the parents concerning the sibling.

NCDSS completed up-to-date safety and risk assessments. The whereabouts and custodial status of all surviving siblings were confirmed and recorded. Three siblings, currently ages 13, 9 and 8, were previously freed for adoption. The mother's rights to a sibling who is now 18 years old were terminated, and her BF had custody for the past 8 years. The mother maintained parental rights of two siblings, ages 14 and 1, but did not have custody. The 14-year-old's BF's rights were terminated and after living with MGM, she recently went into the custody of a family friend. The 1-year-old remained in the MGM's custody after being removed shortly after birth from the mother and his BF.

NCDSS' documentation supported the determination of each allegation. When all casework activity was complete, NCDSS closed the investigation.

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:
Safety assessments were timely and appropriate. The overall determination, as well as the determination of each specific allegation, was appropriate given the supportive evidence gathered.

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 decision to close the case was appropriate, and there was evidence of supervisory consultation throughout the case record.

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: 04/06/2007 **Time of Death:** 11:40 AM

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

County where fatality incident occurred: Niagara
Was 911 or local emergency number called? Yes
Time of Call: 10:59 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? 3 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	Aunt/Uncle	No Role	Female	13 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	25 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)

Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	45 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	50 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Other Deceased Child - Sibling; born and died after fatality	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)

LDSS Response

Immediately upon receiving the SCR report, NCDSS coordinated amongst their multidisciplinary team and began gathering information. NCDSS promptly gathered historical information concerning the two child deaths, and assessed the current safety of surviving siblings. NCDSS found neither parent had any children in their care or primary custody, nor did they have children residing in their homes.

In documentation received from law enforcement, NCDSS learned the following: Police responded to the parents' home on 4/6/07 after a 911 call about the subject child not breathing. Fire department personnel arrived and took over the paternal grandmother's CPR efforts. Police noted the baby was pale and unresponsive. He was rushed to the hospital where resuscitative efforts continued. He presented in cardiac arrest and was not able to be revived. Police spoke with the parents and grandmother, who reported the infant was placed in a bassinet that evening (bassinet described as small and portable). While sleeping in it, one of the parents moved the bassinet from a bedroom and placed it on the couch. Later, one of the parents checked on the infant and found him unresponsive. Police documented observations, and it was not noted that anything else was in the bassinet with the baby. The criminal investigation closed later that year after police learned the autopsy results.

NCDSS re-interviewed the mother, father, and paternal grandmother about the subject child's death. The father recalled he fed the child that morning around 8AM then went back to bed downstairs. He said the mother brought the child down before noon, still in his bassinet. When he picked up the baby, he saw blood coming from his nose and noticed he was not breathing. The position of the baby when placed to sleep and when found was not noted.

NCDSS spoke with the District Attorney, who confirmed there would be no new criminal investigation of the fatality unless new disclosures were made. NCDSS' investigation revealed there was no new information, and since the death was deemed natural, the allegations against the parents for the subject child were unsubstantiated.

The death of the second child, who died of asphixiation consequential to severe neglect of the parents, had twice been investigated by NCDSS – once in 2010 and again in 2017. In response to the first investigation, both parents were indicated for DOA/Fatality and inadequate guardianship, in addition to several other abuse and maltreatment allegations in a concurrent investigation. There were four surviving siblings who were also maltreated; they were placed in protective custody. The parents were criminally charged with manslaughter and served time in prison – three years for the mother, and six for the father. Both subsequent fatality investigations revealed no information that was not already known in 2010.

As in the initial fatality investigation, the subsequent investigations about this fatality were indicated against the parents.

NCDSS gathered and recorded safety and risk-related information for the surviving siblings. The three children the mother and father had together resided with adoptive parents. The mother's other two children, to whom she still had visitation rights, resided in the custody of alternate caregivers. The father was on parole and house arrest, and was not permitted around children. The mother was also on parole. NCDSS assessed the safety of a newborn of whom the father verbally acknowledged paternity, though concerns arose when the PGM brought the infant and his mother to the father's home. NCDSS became aware and saw to the baby's protection; he went into the care of a maternal relative.

A discussion was held with the family about potential service needs. No needs were identified with respect to the death of the subject child. Services were previously provided to the family several years ago, following the death of the sibling. No services appeared necessary, and none were initiated.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050525 - Deceased Child, Male, 1 Mons	050532 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
050525 - Deceased Child, Male, 1 Mons	050533 - Father, Male, 22 Year(s)	DOA / Fatality	Unsubstantiated
050525 - Deceased Child, Male, 1 Mons	050533 - Father, Male, 22 Year(s)	Inadequate Guardianship	Unsubstantiated
050525 - Deceased Child, Male, 1 Mons	050532 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
050528 - Sibling, Female, 2 Year(s)	050534 - Grandparent, Female, 45 Year(s)	Inadequate Guardianship	Unsubstantiated
050528 - Sibling, Female, 2 Year(s)	050533 - Father, Male, 22 Year(s)	Excessive Corporal Punishment	Substantiated
050528 - Sibling, Female, 2 Year(s)	050532 - Mother, Female, 21 Year(s)	Excessive Corporal Punishment	Substantiated
050528 - Sibling, Female, 2 Year(s)	050532 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
050528 - Sibling, Female, 2 Year(s)	050533 - Father, Male, 22 Year(s)	Lack of Supervision	Substantiated

050528 - Sibling, Female, 2 Year(s)	050532 - Mother, Female, 21 Year(s)	Lack of Supervision	Substantiated
050528 - Sibling, Female, 2 Year(s)	050533 - Father, Male, 22 Year(s)	Inadequate Guardianship	Substantiated
050528 - Sibling, Female, 2 Year(s)	050534 - Grandparent, Female, 45 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
050528 - Sibling, Female, 2 Year(s)	050533 - Father, Male, 22 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
050528 - Sibling, Female, 2 Year(s)	050532 - Mother, Female, 21 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050534 - Grandparent, Female, 45 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050532 - Mother, Female, 21 Year(s)	Lack of Supervision	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050532 - Mother, Female, 21 Year(s)	Swelling / Dislocations / Sprains	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050533 - Father, Male, 22 Year(s)	Internal Injuries	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050533 - Father, Male, 22 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050533 - Father, Male, 22 Year(s)	Lack of Supervision	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050532 - Mother, Female, 21 Year(s)	DOA / Fatality	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050533 - Father, Male, 22 Year(s)	Swelling / Dislocations / Sprains	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050532 - Mother, Female, 21 Year(s)	Lacerations / Bruises / Welts	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050533 - Father, Male, 22 Year(s)	Lacerations / Bruises / Welts	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050533 - Father, Male, 22 Year(s)	Inadequate Guardianship	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050532 - Mother, Female, 21 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050534 - Grandparent, Female, 45 Year(s)	Inadequate Guardianship	Unsubstantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050533 - Father, Male, 22 Year(s)	DOA / Fatality	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050532 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
050626 - Other Deceased Child - Sibling; born and died after fatality, Female, 1 Year(s)	050532 - Mother, Female, 21 Year(s)	Internal Injuries	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:
Due to the amount of time that passed since the fatality, not everyone present the day the SC died was interviewed; however, relevant information was gathered from caretakers and first responders who were present that day.

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: Services were discussed, though none were initiated during the investigation. Some family members discussed seeking some community-based services on their own.				

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: Siblings were removed from the parents in 2010 in response to the death of the subject child's 1-year-old sibling. All surviving siblings remained in the care of other adults from that time and throughout this investigation.				

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	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Though there was no apparent need for services in response to the infant's death that occurred 12 years ago, NCDSS did discuss services with the family with regard to what they felt they may benefit from. Some services were either being provided or sought outside the child welfare system. Those discussed included: MH, substance abuse treatment, stress management classes, and Early Intervention.

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? No
Explain:
There were no identified service needs with regard to the death of the subject child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There were no identified service needs with regard to the death of the subject child.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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

No history is on record prior to the SC's death.

NCDSS investigated 3 reports of abuse and neglect against the parents and other caregivers beginning 3/31/10. All 5 SS were severely maltreated by the parents; the 1yo died as a result. Substantiated allegations included DOA/Fatality, II, XCP, S/D/S, L/B/W, IF/C/S & IG. NCDSS removed the SS and on 8/26/10, another SS was born and removed; the associated report was also IND against them.

A COI dated 1/21/11 was UNF for the second eldest SS's BF and SM; in 2013 while she was in MGM's care, a report for EN & IG against PGM & PGF was UNF. In 2014 while the eldest SS was in her BF's custody, a disclosure was made and the SF was IND for SA & IG of that child.

A SS born in 2017 was removed; SM and his BF were IND for IG, the BF was also IND for PD/AM. The SS was placed with MGM but removed after an IND report against her on 5/17/17; he returned to her custody in 2018. Also in 2017, MGM was IND for CD/A, IG & LS of the elder of the two SS in her custody. Two reports against her in 2018 were UNF: one for IG & L/B/W of the younger SS; the other alleging SA of the elder SS, and IG & LS of both. Another report in 2018 was IND regarding the elder SS, for SA against SM's boyfriend.

SF and PGM were IND in a report dated 3/1/19 concerning the SF's newborn with another woman. That SS was placed in the custody of his MA.

FC and CPS services were provided to the family from 4/6/10 to 1/25/15, and again from 4/9/17-9/17/18.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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