Child Fatality Report

Report Identification Number: BU-23-040

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

Issue Date: Mar 04, 2024

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 4 month(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 11/10/2023
Initial Date OCFS Notified: 11/10/2023

Presenting Information

Three SCR reports were received on 11/10/23, which alleged that the mother was caring for the subject child while the father was at work. When the father returned home, he went to check on the 4-month-old subject child and found the child unresponsive. The father began cardiopulmonary resuscitation (CPR) and called 911. The ambulance transported the child to the hospital, where he was pronounced deceased at 8:44AM. The child was an otherwise healthy child, and the parents did not have an explanation for his death. It was believed the parents were co-sleeping with the child and the cause of death was asphyxiation. It was further alleged the parents were not providing adequate housing as the home was in deplorable condition. The home was infested with mice, there was garbage, moldy food, dirty diapers, and mouse droppings throughout the home.

Executive Summary

This report concerns the death of the 4-month-old subject child. Niagara County Department of Social Services (NCDSS) received multiple SCR reports regarding the child's death on 11/10/23. At the time of the child's death, he resided with his mother, father, and siblings; a 4-month-old twin, and 3-year-old.

On the evening of 11/9/23, the mother was home with the children and the father worked his regular overnight shift. The mother fed and burped the twins at 11:30PM and got into bed with the children. The family regularly co-slept, sharing a queen-sized bed. In the bed that evening was the mother, subject child, twin sibling, and the 3-year-old sibling. The mother checked on the children at 2:30AM the morning of 11/10/23 and went back to sleep. The father got out of work at 4:00AM that morning and returned home. He fell asleep in the living room and awoke at 7:00AM in order to wake the mother for work and prepare the twins' bottles. Upon waking, the mother noticed something was wrong with the subject child; he was face-down, with his head slightly to the side. The mother yelled to the father. The father realized the subject child was not breathing and called 911. Dispatch instructed the father on how to perform CPR. Emergency medical services (EMS) arrived and continued CPR en route to the hospital. The child was pulseless upon arrival and did not respond to medical interventions. The child was pronounced deceased at 8:44AM.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation was closed. A law enforcement officer stated the medical examiner reported there was no trauma observed and the death appeared to be from unsafe sleep. Toxicology results were pending. The record did not reflect NCDSS attempted to contact the medical examiner. Emergency department staff also reported no findings of trauma. NCDSS documented the death was believed to be from asphyxiation. Law enforcement investigated and no charges were brought against the parents.

NCDSS made several home visits and interviewed the parents. The home was found to be in deplorable condition and condemned by Code Enforcement. The surviving siblings stayed with relatives until the parents secured appropriate housing. NCDSS filed Neglect petitions against the parents and court-ordered services were put in place and a services case was opened for ongoing monitoring.

The report was indicated, and the allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter were substantiated. The Investigation Conclusion Narrative stated the parents disclosed regularly co-sleeping with the three children since birth. The subject child and twin sibling were born prematurely; however, medical collaterals noted no underlying health conditions. The home was described to have several health and safety concerns. There was an

overwhelming odor of urine and dirt, rooms were cluttered with toys, piles of clothes, and food. The entire first floor was covered in mouse droppings and soaked with mouse urine. Soiled diapers and bags full of trash were in the bedroom. The bathtub had black water and mildew and the queen-sized mattress the family shared was stained with dirt and contained four pillows and a comforter. There was a Pack 'n Play and toddler bed, both of which contained mouse droppings, and the walls and cabinets were stained with dirt. It was also believed the mother had untreated mental health diagnoses; however, the Narrative did not indicate how that affected the children. NCDSS unsubstantiated DOA/Fatality, stating it was believed the child died because of an unsafe sleep environment; however, the cause of death was pending. The parents denied knowing the risks associated with co-sleeping and have ceased the practice since CPS intervention.

The parents accepted services offered by NCDSS and a services case was opened on 12/8/23.

PIP Requirement
This review resulted in citations. NCDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) NCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, NCDSS will review the plan and revise as needed to 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:
The determination to indicate the report was accurate; however, the determination for DOA/Fatality was incongruent with the record. The record reflected a law enforcement officer stated the medical examiner reported the death appeared to be a result of unsafe sleep. Additionally, the record stated it was believed the child died from asphyxiation.

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:
Due to court-ordered services and ongoing family court involvement, a services case was opened and the family's participation in services continued to be monitored by NCDSS.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The record reflected it was believed the child died from asphyxiation and because of an unsafe sleep environment. The RAP indicated the child's death was a result of abuse/maltreatment by a caretaker; however, DOA/Fatality was unsubstantiated.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	NCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Buffalo Regional Office if further guidance is needed.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The 30-Day and determination Safety Assessments were inconsistent with the record. Despite documentation that judicial intervention was required and initiated by the filing of Neglect, the assessments documented no safety factors present.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The condition of the home was found to be deplorable and condemned by Code Enforcement. Due to the condition of the home, the siblings had to stay elsewhere until adequate housing was secured. The recent safety hazards in the home were not reflected.
Legal Reference:	18 NYCRR 432.2(d)
Action:	NCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/10/2023 **Time of Death:** 08:44 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: 07:43 AM
Did EMS respond to the scene? Yes

At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown

Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ 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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)

LDSS Response

On 11/10/23, NCDSS received three reports regarding the death of the subject child. NCDSS coordinated efforts with law enforcement, notified the DA, gathered information about the incident, and assessed the safety of the surviving siblings.

NCDSS completed casework and collateral contacts and learned on the evening of 11/9/23, the mother was home with the children, and the father was at work. The parents reported they were told to have the twins sleep together in one crib, though did not specify who told them that, and said they regularly co-slept with the children since the birth of the 3yo sibling. Around 9:50PM, the family left to drive the father to work, and when the mother returned with the children, they all got into bed. The mother fed the twins their bottles at 11:30PM, burped them, then remained in bed with the children, playing a game on her phone until she fell asleep. The mother said she checked on the children at 2:30AM, by poking them, and then went back to sleep. The surviving twin was sleeping near the mother's head. The mother drew a picture of how they were positioned in the bed that night; however, a description of the picture was not documented in the record and therefore, the position of the family members in the bed was unknown. The father got out of work at 4:00AM, earlier than usual, and returned home. He played a video game in the living room and fell asleep. He awoke again at 7:00AM, woke the mother, and proceeded to make the twins' bottles. The mother yelled to the father there was something wrong with the subject child. The mother had found the child face-down, with his head turned slightly to the right. The father ran into the room and upon realizing the child was not breathing, called 911 and started CPR.

NCDSS contacted numerous collateral sources, including EMS, law enforcement, hospital staff, the coroner, and the pediatrician's office. It was learned the twins were born prematurely at 30 weeks gestation and the subject child was in the hospital about a month following birth. Pediatric records reflected the subject child received routine well-care without abnormal findings and that safe sleep practices were reviewed, specifically to position the child on their back for sleep in a crib or bassinet.

Due to the safety hazards observed in the home, the siblings stayed with relatives until the parents were able to secure suitable housing. NCDSS assisted the parents in applying for housing assistance and assessed their new residence to be

appropriate. Safe sleep practices were reviewed with the parents and a Pack ‘n Play was provided for the 4-month-old sibling. The parents were observed to be following safe sleep recommendations during subsequent home visits.

NCDSS filed Neglect in family court on behalf of the subject child and siblings and the first appearance occurred on 11/28/23. The petition cited the three SCR reports received regarding the subject child’s death, and that while the cause of death was pending, it was believed the child died from asphyxiation. Although born prematurely, there were no underlying health conditions and the parents had disclosed co-sleeping with the children since birth. The home was found to be below minimal standards and subsequently condemned. Additionally, the petition stated the mother had untreated mental health diagnoses and had not engaged in treatment since the birth of the 3yo sibling. Court-ordered services were requested by NCDSS and consented to by the parents.

In response to the ongoing service needs, a family services stage was opened, and service referrals were made on behalf of the parents. The siblings were assessed to be safe with the parents in the new residence and the family was engaged in services and compliant with home visits at the conclusion of the CPS investigation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066249 - Deceased Child, Male, 4 Month(s)	066252 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
066249 - Deceased Child, Male, 4 Month(s)	066252 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
066249 - Deceased Child, Male, 4 Month(s)	066252 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
066249 - Deceased Child, Male, 4 Month(s)	066253 - Father, Male, 22 Year(s)	DOA / Fatality	Unsubstantiated
066249 - Deceased Child, Male, 4 Month(s)	066253 - Father, Male, 22 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
066249 - Deceased Child, Male, 4 Month(s)	066253 - Father, Male, 22 Year(s)	Inadequate Guardianship	Substantiated
066250 - Sibling, Female, 4 Month(s)	066252 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
066250 - Sibling, Female, 4 Month(s)	066252 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
066250 - Sibling, Female, 4 Month(s)	066253 - Father, Male, 22	Inadequate Food / Clothing /	Substantiated

	Year(s)	Shelter	
066250 - Sibling, Female, 4 Month(s)	066253 - Father, Male, 22 Year(s)	Inadequate Guardianship	Substantiated
066251 - Sibling, Female, 3 Year(s)	066252 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
066251 - Sibling, Female, 3 Year(s)	066252 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
066251 - Sibling, Female, 3 Year(s)	066253 - Father, Male, 22 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
066251 - Sibling, Female, 3 Year(s)	066253 - Father, Male, 22 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:

NCDSS obtained information from the ME through law enforcement. It was unknown if the autopsy report was requested and/or received. NCDSS spoke with the coroner, who responded to the fatality, though a cause of death was not discussed.

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:
The Risk Assessment Profile was scored inconsistently with the record; however, appropriate services were offered and accepted.

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
Although there was an adequate assessment of safety; the 30-Day Safety Assessment and the Investigation Determination Safety Assessment tools did not accurately reflect case circumstances at the time. Both assessments indicated there were no safety factors present; however, NCDSS had filed Neglect against the parents and there was ongoing judicial intervention and court-ordered services in place.

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:**
11/21/2023	There was not a fact finding	Order of Supervision
Respondent:	066252 Mother Female 23 Year(s)	
Comments:	NCDSS filed a Neglect petition against the parents on behalf of the subject child and surviving siblings. The first appearance occurred on 11/28/23. NCDSS requested court-ordered services. The following services were consented to; the parents were to cooperate with NCDSS, the parents were to obtain and maintain adequate housing, the parents were to participate in parenting services, the mother was to obtain a mental health evaluation and follow through with any recommendations, the father was to obtain a substance use evaluation and follow through with any recommendations, the parents were to comply with safe sleep recommendations, and the parents were to refrain from the use of illegal drugs and ensure there was a sober caretaker for the siblings at all times. Court was ongoing at the time the CPS investigation closed and the next court date was in January 2024.	

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: Preventive Services

Additional information, if necessary:
The services case reflected the parents had been proactive in seeking mental health and substance use treatment, as the father was known to use marijuana. It was unknown if ongoing treatment was recommended. Although the case was indicated, an Early Intervention referral was not made on behalf of the eligible sibling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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 a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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

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

Known CPS History Outside of NYS

There was no known 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.

Additional Local District Comments

NCDSS fatality team members will refer to OCFS guidelines for when it is appropriate to Indicate or Unfound reports. The record stated the child was believed to expire from asphyxiation which was consistent with parents reporting. NCDSS Fatality Team supervisors and caseworkers will review the indications / unfoundings prior to the closing of the report.

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