



Report Identification Number: NY-18-013

Prepared by: New York City Regional Office

Issue Date: Aug 03, 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 year(s)

Jurisdiction: Kings
Gender: Male

Date of Death: 02/08/2018
Initial Date OCFS Notified: 02/08/2018

Presenting Information

On 2/8/18, the SCR registered a report that alleged DOA/Fatality and IG of the SC by the biological parents.

The report alleged at 3:30 P.M. on 2/8/18, the BF contacted 911 because the SC was unresponsive and not breathing. With the guidance of the 911 operator over the phone, the BF administered CPR to the SC before EMS arrived to the home. The SC was transported to the hospital by EMS. At 6:09 P.M., hospital staff pronounced the SC dead for unknown causes. The report also alleged although the SC was sick on the day of his death, he did not have any preexisting conditions or prior health issues and was a healthy child. The parents did not provide any plausible explanation regarding the SC's cause of death, which deemed his death suspicious. Both parents were the caregivers of the SC at the time of his death.

Executive Summary

The one-year-old male SC died on 2/8/18 while in the care of his biological parents (BPs). The ME's autopsy resulted in a finding that the cause and manner of death were undetermined. ACS documentation reflected the SC had fallen ill and was seen at approximately 1:00 A.M. on 2/8/18, at the Brookdale Hospital ER due to his medical condition. At 5:30 A.M., he was discharged and prescribed medication. While in the home, the SC fell ill again and at 4:05 P.M., the BPs and LE brought the SC back to Brookdale Hospital. The medical staff attempted to revive the SC; however, he was pronounced dead at 6:09 PM.

On 2/8/18, ACS initiated the investigation by contacting the family, LE, school and medical personnel. The information obtained from these collaterals revealed the BPs were not negligent regarding the SC's death. The collaterals stated the BPs acted appropriately and sought medical attention for the SC on two occasions on the day of his death. The investigation revealed the family was providing adequate care to all their children. LE did not find any criminality in the SC's death.

The family reported disappointment and frustration with the hospital for discharging the SC so quickly after the initial examination. The BM stated at the time of his discharge, the SC still had medical issues; however, the medical staff discharged the SC and stated he would be okay. ACS assessed the SS and they were deemed safe in the family's home. During the investigation, ACS conducted a child safety conference (CSC) that recommended PPRS services which the family refused.

The BM arranged to have the SS medically assessed following the SC's death. There were no concerns for the SS. Throughout the investigation, ACS utilized language services at every casework contact with the BPs who only communicated in Arabic. The older SS spoke English.

On 5/9/18, ACS unsubstantiated the allegations of the report against the BPs. ACS determined the BPs were not negligent and sought medical attention on two occasions the same day prior to the SC's death. The SC was taken to the hospital and discharged with medication which the BPs administered to the SC as prescribed. He was transported back to the hospital later the same day by the police when he became unresponsive.

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

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 refused services but all the SS were deemed safe in the care of their BPs; however, ACS determined the report and the case remained open for services when ACS is providing no services.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Child Protective Services casework contacts
Summary:	The case notes reflected the 911 call was made at three different times; 2:00 PM, 3:30 PM, and 4:10 PM. Also, the BM stated that EMS did not respond to the home soon enough, so she called the police. ACS did not contact EMS to address these concerns.
Legal Reference:	432.2(b)(4)(vi)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS attempted contacts on 2/8/18 and 3/3/18 with the attending Dr. but did not make follow up contact with the Dr. to address the concerns raised by the BM regarding the assessment and medical care the SC received prior to his initial discharge.



Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	Although ACS submitted the 30-Day Fatality Report the co-requisite safety assessment was not submitted timely.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/08/2018

Time of Death: 06:09 PM

County where fatality incident occurred:

Kings

Was 911 or local emergency number called?

Yes

Time of Call:

03:30 PM

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? 1 Hours

Is the caretaker listed in the Household Composition? Yes - Caregiver 2

At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
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Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

On 2/8/18, ACS contacted the responding LE and medical staff. They both stated that at 1:00 AM, the SC was seen at the hospital for a medical condition. LE stated no arrests were made pending autopsy results. LE described the family's home as messy but not hazardous. At 5:30 AM, the SC was discharged home with prescribed medication.

ACS then visited the family at the case address. The BM provided an account of the incident which was consistent with the SC being taken to the hospital on two separate occasions prior to his death. She stated that the SC still had medical difficulties when he was initially discharged. The BM protested the SC being discharged so soon but the medical staff assured her the SC would be fine. The BM took the SC home and at about 10:00 AM, the SC fell ill again and the BM gave him medication as prescribed. At approximately 3:30 PM, the BM called 911. She stated that EMS did not come soon enough so she called the police.

The BF refused to be interviewed. The relatives who were in the home also refused to speak with ACS. They asked for time to allow the family to grieve. ACS staff interviewed the older SS separately. They were aware their youngest brother had died. They denied their BPs physically disciplined them. ACS deemed all the SS to be safe in the home. ACS advised the BM to take the SS to the doctor to be medically cleared. The BM reported that the SS were healthy and their immunizations were current. The SC did not have any preexisting medical issues and the BM agreed to have the SS children seen by their physicians.

On 2/9/18, ACS visited the older SS' school. ACS documented the school staff did not report any concerns about their behavior or academics. The staff stated the BPs were very involved with the SS' education. The school agreed to provide counseling services to the SS.

On 2/9/18 and 2/13/18, ACS visited the family. The family did not provide any new information about their son's death; however, they stated the hospital did not provide the SC with proper medical care at the time he was discharged. The parents declined ACS' offer of services.

On 2/15/18 and 2/22/18, ACS received the children's immunization records from the immunization registry and their medical information from the pediatrician. The children's immunizations were current. The SC was last seen on 9/5/17 for a care visit. The pediatrician did not report any concerns for the family.

On 3/3/18, ACS visited the family and observed all the SS to be free of marks and or bruises. The home was clean and well organized. ACS staff observed the documentation that indicated the children were medically assessed on 2/9/18. The three older SS were diagnosed with influenza and prescribed medication. The younger SS was also prescribed medication for an ear infection. ACS provided the family with referral for PPRS services at the Arab American Family Support Center agency and the family declined ACS' offer and the parents arranged for services.

On 3/20/18, the ME reported that an autopsy was not done due to the family's religion. An external examination



completed revealed there was no trauma to the SC. The cause and manner of death was undetermined.

On 4/11/18, ACS held a child safety conference and recommended PPRS services to the family but they refused services.

Between 4/9/18 and 5/2/18, ACS made several casework contacts with the family and other collaterals. There was no new information about the SC's death. Also, there were no concerns for all the SS in the care of their BPs. The older SS continued to attend school and there was no behavioral change reported by the school.

On 5/9/18, ACS unsubstantiated the allegations of the report against the BPs. ACS kept the case open for services despite the fact the family repeatedly declined ACS' offers for services.

Official Manner and Cause of Death

Official Manner: Undetermined

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)?No

Comments: The investigation adhered to approved protocols for joint investigation.

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

Comments: New York City does not have an 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
044207 - Deceased Child, Male, 1 Yrs	046800 - Father, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
044207 - Deceased Child, Male, 1 Yrs	046799 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
044207 - Deceased Child, Male, 1 Yrs	046799 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
044207 - Deceased Child, Male, 1 Yrs	046800 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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Explain:
Although ACS completed the 30-Day fatality report, the co-requisite safety assessment was not completed.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Intensive case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Family or others as safety resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Additional information, if necessary:
The family declined ACS' offers for services.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No

Explain:

The family declined all ACS' offers for services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No

Explain:

ACS provided the family referral for bereavement counseling services for the family but they refused services.

History Prior to the Fatality

Child Information

- Did the child have a history of alleged child abuse/maltreatment? No
- Was there an open CPS case with this child at the time of death? 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? Yes

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 family was not known to the SCR or to ACS prior to the fatality report.

Known CPS History Outside of NYS

The family did not have any 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