Child Fatality Report

Report Identification Number: NY-23-047

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

Issue Date: Oct 17, 2023

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: 2 month(s)
Jurisdiction: New York
Gender: Female
Date of Death: 05/11/2023
Initial Date OCFS Notified: 05/11/2023

Presenting Information

Two SCR reports were received on 5/11/23 and alleged that the mother and father failed to provide a safe sleep environment for the 2-month-old female subject child. The child was placed to sleep in the same bed as the mother, father, and the 2-year-old sibling. As a result, the child became unresponsive, was not breathing, and had blood coming from her nose. The mother called 911 and first responders arrived and transported the child to the hospital where she was pronounced deceased at 6:26 AM. Additionally, the mother, father, and the grandmother were aware that the home presented as a safety hazard to the children, but failed to adequately address the situation. As a result, the home was cluttered with various large and small items, and there was no safe pathway in case of an emergency.

Executive Summary

This fatality report is regarding the death of the 2-month-old female child that occurred on 5/11/23. Two SCR reports were made on the same day. The initial report included allegations of Inadequate Guardianship and Inadequate Food/Clothing/Shelter against the parents and grandmother regarding the subject child, 1-year-nephew, and three siblings, ages 15, 5, and 2 years. The subsequent included the allegation of DOA/Fatality against the parents regarding the subject child. At the time of her death, the child resided with her parents, grandmother, nephew, and siblings. The adult sibling(mother to the 1-year-old nephew) resided in the home but was attending school in another state at the time of the fatality. The surviving children were determined to be safe in the care of the parents.

The Administration For Children's Services (ACS) coordinated investigative efforts with law enforcement. It was learned on the morning of 5/11/23 at 12:00 AM, the mother fed the subject child, burped her, and placed her to sleep swaddled and on her back in a DockATot. The DockATot was positioned between the parents on their queen-sized bed. The 2-year-old sibling also slept in the same bed. The child fell asleep at 1:30 AM and the mother afterward. In the morning, the mother woke up and noticed the child had mucus at the corner of her mouth. When the mother went to clean the child, she realized it was blood and that the child was unresponsive. The mother picked the child up and realized she was not breathing. The mother woke the father and they called 911 and initiated cardiopulmonary resuscitation. First responders arrived and transported the child to the hospital where she was pronounced deceased at 6:26 AM.

An autopsy was performed and the final results were not yet available at the time the CPS investigation was closed. ACS spoke with the medical examiner's office and it was reported there were no significant findings of major trauma, no findings of major internal or external injuries, no findings of natural disease, and no findings of abnormality. Law enforcement investigated the death and there were no criminal charges when the CPS investigation was closed. Their investigation was pending receipt of the final autopsy results.

The allegation of Inadequate Guardianship was incorrectly unsubstantiated against the mother and father regarding the subject child. The record reflected that the mother and father regularly placed the subject child in an unsafe sleep environment, including in a DockATot on an adult-sized bed with the parents and sibling, putting the child in imminent danger of harm. The allegation of DOA /Fatality was unsubstantiated against the parents. At the time the CPS investigation was closed, sufficient evidence was not gathered to corroborate that the child being placed in an unsafe sleep environment contributed to the death. ACS documented that should additional information be discovered that indicated there was neglect or abuse related to the child's death, an SCR report would be made. Allegations regarding the condition of the home against the parents and grandmother were unsubstantiated. The home environment was assessed and observed to be cluttered with various items; however, it was not determined to be a health or safety hazard to the children's safety

and well-being.

ACS provided the family with daycare assistance, deep cleaning services, early intervention referrals, funeral assistance, a toddler bed, and a resource packet with information regarding community-based services. The family was offered bereavement counseling and declined. The family declined preventive services; however, a case was opened to provide ongoing referrals for services. The CPS investigation was closed on 7/10/23.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS 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?** No

Explain:

Although sufficient information regarding the allegations was gathered during the investigation, an incorrect determination was made in regard to Inadequate Guardianship.

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:

Casework activity was not commensurate with statutory or regulatory requirements, as the record did not reflect efforts to identify and interview the father of the nephew and the determination was not appropriate.

Required Actions Related to the Fatality

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:	The record did not reflect efforts to identify the father of the 1-year-old nephew; therefore, he was not notified of or interviewed regarding the SCR report.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.
Issue:	Appropriateness of allegation determination
Summary:	Though the criteria regarding a fair preponderance of evidence was met with the information documented in the case record, ACS did not appropriately determine Inadequate Guardianship.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/11/2023 **Time of Death:** 06:26 AM

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

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 05:45 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	Adult Sibling	No Role	Female	21 Year(s)

Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	42 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	68 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Other Child - Nephew	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	15 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	5 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)

LDSS Response

Upon receipt of the SCR reports on 5/11/23, ACS coordinated efforts with law enforcement, sent notification to the Medical Examiner, interviewed the family, gathered information from medical collaterals, and assessed the safety of the surviving children.

ACS interviewed the mother and father at their home regarding the incident. The parents reported no abnormalities with the child leading up to her death. On 5/11/23 at 12:00 AM, the mother fed and burped the child and laid her down in her DockATot. The mother took a shower and when she finished, swaddled the child and placed her on her back in the DockATot where she fell asleep around 1:30 AM. The mother woke in the morning and noticed the child had blood on her mouth and was unresponsive and not breathing. The father was woken by the mother who told him the child was not breathing. The father called 911 and the mother initiated cardiopulmonary resuscitation. First responders arrived and transported the child to the hospital where she was pronounced deceased. The grandmother was interviewed and provided no additional information regarding the incident. She had no concerns for the child's well-being.

The parents reported that the child was born prematurely at 31 weeks due to medical issues of the mother. The parents stated that while the child was healthy, she was allergic to formula and they were working on remedies with the pediatrician to ease the child's acid reflux. The parents confirmed the child co-slept with them using the DockATot. The mother was aware of safe sleep guidelines; however, it was unclear if the father was, as he did not understand why an infant should not sleep with their parents. The parents denied any substance misuse, domestic violence, criminal activity, or any other child welfare concerns.

ACS conducted a child safety conference in which the safety of the surviving children was discussed and the need for services was assessed. It was determined the circumstances of the investigation did not warrant family court intervention. The family was receptive to community-based services. ACS completed multiple face-to-face contacts with the surviving children. The 1-year-old nephew and 2-year-old sibling were not interviewed due to their age, but their safety was otherwise assessed. The record reflected an attempt to interview the 5-year-old sibling; however, he would not fully participate in the interview. The 15-year-old sibling was interviewed and did not disclose any child welfare concerns. The 15-year-old reported she was in her room when the first responders arrived at the home. The sibling was informed by the grandmother that the child was not breathing. The sibling reported no concerns for the subject child leading up to her death. ACS documented efforts to obtain information regarding the 5 and 15-year-old's fathers; however, the mother would not cooperate in providing any identifying information on them. The record did not reflect efforts to identify the father of the nephew or provide him with information regarding the SCR report.

ACS conducted visits to the home and assessed the concerns regarding its condition as alleged in the SCR report. The home was cluttered and contained several items, including clothing, car seats, toys, and strollers. ACS determined the children were able to move freely throughout the home, and the condition did not impact their safety or well-being. The family had appropriate clothing, ample food, and a crib for the child. The mother reported the home was cluttered due to

the amount of people residing in it, and that when first responders arrived, their items were shuffled around making the home appear in worse condition. ACS provided cleaning services to the family to assist in decluttering the home.

Fatality-related services were provided to the family and ACS opened a Preventive Services case to continue to monitor the needs of the family and make referrals as necessary.

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?No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064869 - Deceased Child, Female, 2 Mons	064870 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064869 - Deceased Child, Female, 2 Mons	064872 - Father, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
064869 - Deceased Child, Female, 2 Mons	064872 - Father, Male, 42 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064869 - Deceased Child, Female, 2 Mons	064870 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
064869 - Deceased Child, Female, 2 Mons	064871 - Grandparent, Female, 68 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064869 - Deceased Child, Female, 2 Mons	064871 - Grandparent, Female, 68 Year(s)	Inadequate Guardianship	Unsubstantiated
064869 - Deceased Child, Female, 2 Mons	064872 - Father, Male, 42 Year(s)	DOA / Fatality	Unsubstantiated
064869 - Deceased Child, Female, 2 Mons	064870 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
064874 - Sibling, Female, 15 Year(s)	064872 - Father, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
064874 - Sibling, Female, 15 Year(s)	064870 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064874 - Sibling, Female, 15 Year(s)	064872 - Father, Male, 42 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064874 - Sibling, Female, 15 Year(s)	064871 - Grandparent, Female, 68 Year(s)	Inadequate Guardianship	Unsubstantiated

064874 - Sibling, Female, 15 Year(s)	064870 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
064874 - Sibling, Female, 15 Year(s)	064871 - Grandparent, Female, 68 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064875 - Sibling, Male, 5 Year(s)	064872 - Father, Male, 42 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064875 - Sibling, Male, 5 Year(s)	064872 - Father, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
064875 - Sibling, Male, 5 Year(s)	064871 - Grandparent, Female, 68 Year(s)	Inadequate Guardianship	Unsubstantiated
064875 - Sibling, Male, 5 Year(s)	064870 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
064875 - Sibling, Male, 5 Year(s)	064870 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064875 - Sibling, Male, 5 Year(s)	064871 - Grandparent, Female, 68 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064876 - Sibling, Female, 2 Year(s)	064872 - Father, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
064876 - Sibling, Female, 2 Year(s)	064870 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
064876 - Sibling, Female, 2 Year(s)	064872 - Father, Male, 42 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064876 - Sibling, Female, 2 Year(s)	064871 - Grandparent, Female, 68 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064876 - Sibling, Female, 2 Year(s)	064870 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064876 - Sibling, Female, 2 Year(s)	064871 - Grandparent, Female, 68 Year(s)	Inadequate Guardianship	Unsubstantiated
064877 - Other Child - Nephew , Male, 1 Year(s)	064872 - Father, Male, 42 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064877 - Other Child - Nephew , Male, 1 Year(s)	064871 - Grandparent, Female, 68 Year(s)	Inadequate Guardianship	Unsubstantiated
064877 - Other Child - Nephew , Male, 1 Year(s)	064870 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064877 - Other Child - Nephew , Male, 1 Year(s)	064871 - Grandparent, Female, 68 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
064877 - Other Child - Nephew , Male, 1 Year(s)	064872 - Father, Male, 42 Year(s)	Inadequate Guardianship	Unsubstantiated
064877 - Other Child - Nephew , Male, 1 Year(s)	064870 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated

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?	☐	☒	☐	☐
School	☐	☒	☐	☐
Daycare Provider	☐	☒	☐	☐
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:
The record reflected the mother refused to sign consent for ACS to speak to the school regarding the 5 and 15-year-olds, as she did not want them to be aware of her CPS involvement. The record did not reflect if the daycare was contacted.

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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

In 2003, the mother had a CPS investigation in which she was unsubstantiated for Inadequate Guardianship regarding the adult sibling.

In 2009, the grandmother had an indicated CPS investigation with substantiated allegations of Lack of Supervision and Inadequate Guardianship regarding the adult sibling and 15-year-old sibling.

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