# Child Fatality Report

## Report Identification Number: NY-23-122

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

## Issue Date: May 07, 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:** 2 month(s)
**Jurisdiction:** Richmond
**Gender:** Female
**Date of Death:** 12/14/2023
**Initial Date OCFS Notified:** 12/14/2023

### Presenting Information

An SCR report alleged on 12/14/23, around noon, the SM placed the 2-month-old SC down for a nap in an unknown environment. The SM periodically checked on the SC over the next few hours. When the SM checked on the SC at about 2:50 PM, the SC was on her side, cold and unresponsive. The SM brought the SC to the SF, and he began CPR. The SC bled from her nose. EMS was contacted and transported the SC to the hospital where she was pronounced dead at 4:10 PM. The parents did not have an explanation for the death. On 01/18/24, a subsequent SCR report alleged the parents verbally fought and the SF would physically assault the mother in the presence of the siblings. The SM had visible injuries from the assault. The parents would blow marijuana smoke into the 5-year-old sibling's face, and she would inhale. The parents were aware and continued to blow smoke in the sibling's face.

### Executive Summary

This report concerns the death of the 2-month-old child. A report was made to the SCR on 12/15/23 with concerns the child was placed to sleep for a nap and was later discovered unresponsive. A subsequent report was made on 1/18/24 with concerns the parents would verbally and physically fight in the presence of the siblings and blew marijuana smoke into the 5-year-old sibling's face. At the time of her death, the child resided with her parents and siblings, aged 1 and 5 years. A 2-year-old paternal sibling resided with her mother and did not have contact with the child. The siblings were assessed to be safe with the mothers.

The Administration for Children’s Services (ACS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. The criminal investigation was in the process of closure without any criminal charges filed. An autopsy was performed; however, the autopsy report was not yet available when ACS determined their investigation. The autopsy report was received by OCFS. The cause of death was undetermined (intrinsic and extrinsic factors identified), and the manner of death was undetermined. The autopsy report noted the child was failure to thrive and she was in an unsafe sleeping environment at the time of her death.

The parents were interviewed, and it was reported the mother placed the child down for a nap in her bassinet. The child was placed on her side with a blanket in the bassinet. The parents checked on the child throughout her nap and reported she was fine. The mother checked on the child again approximately 3 hours after placing her to sleep, and the child was unresponsive. The mother alerted the father, who performed CPR while the mother called 911. EMS responded and transported the child to the hospital where she was pronounced deceased. It remained unknown if the parents were educated on safe sleeping recommendations.

ACS contacted collaterals including family members, school staff and the pediatrician. Family members expressed concerns for the father’s physical violence toward the mother; however, the parents denied this. The school staff stated the 5-year-old sibling did not attend school consistently, but interactions with the mother were appropriate. The pediatrician did not have concerns.

The allegations against the parents were unsubstantiated. The Investigation Conclusion Narrative stated the allegation of DOA/Fatality was unsubstantiated as there was a lack of fair preponderance of evidence. The medical examiner reported there were no marks or bruises on the child which would indicate abuse. The parents reported the child was fine before being placed down for a nap. The 5-year-old sibling was placed in a different school to better suit her needs. The parents denied smoking in the presence of the children. The parents denied any domestic violence and there were no law

enforcement records reflecting altercations between the parents. The allegation of Inadequate Guardianship against the mother with regard to the child was inappropriately determined. ACS gathered information that the mother placed the child to sleep on her side and with a blanket which placed the child at risk of harm; however, the Investigation Conclusion Narrative did not reflect this key-related information.

ACS completed required reports and Safety Assessments timely and accurately. Home visits were made and interviews with the family were appropriate. The parents were offered referrals for bereavement services and funeral assistance. The mother declined the counseling services, stating she was not in the right mindset to make decisions. The father accepted the services; it remained unknown if they were utilized. The parents accepted preventive services and the case remained open at the time of this writing.

**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:**
The allegation of Inadequate Guardianship against the parents regarding the child was inappropriately determined.

**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 case remained open for services.

## Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Appropriateness of allegation determination |
| **Summary:** | Although the mother placed the child to sleep on her side with a blanket in the bassinet, the allegation of IG was unsubstantiated. The father was aware the child was in an unsafe sleeping environment and did not intervene to protect her. |
| **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:** 12/14/2023 **Time of Death:** 04:10 PM

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

**County where fatality incident occurred:** Richmond
**Was 911 or local emergency number called?** Yes
**Time of Call:** Unknown
**Did EMS respond to the scene?** Yes
**At time of incident leading to death, had child used and/or ingested alcohol or drugs?** No
**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 | Female | 2 Month(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 23 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 23 Year(s) |
| Deceased Child's Household | Sibling | Alleged Victim | Female | 5 Year(s) |
| Deceased Child's Household | Sibling | Alleged Victim | Female | 1 Year(s) |

## LDSS Response

On 12/15/23, ACS received the fatality report from the SCR. Within the first 24 hours of the investigation, ACS contacted the source of the report, notified the medical examiner and district attorney's offices of the death, and coordinated with law enforcement. The siblings were assessed to be safe with their mothers.

Hospital staff reported that the mother said she fed the child around 12:00 PM and then placed her down to nap. The mother checked on the child at 2:00 PM, and the child was unresponsive and did not have a pulse. The child was transported via ambulance to the hospital, where she was pronounced deceased.

On 12/15/23, the maternal aunt was interviewed over the phone. The mother and children were staying at her home following the death. She said she received a call from the mother stating that she was going to the hospital because the child was not responding. She stated that the mother provided appropriate care to her children, and she did not have concerns for their safety. The aunt expressed concerns for domestic violence, stating the father was the aggressor.

The mother was interviewed and reported the child appeared fine on the day of the death. The mother fed the child around 12:30 PM and put her down for a nap. The mother placed the child on her right side in the bassinet. The mother always placed the child on her right side, stating it was the only way the child would fall asleep. The child was placed in the bassinet with a blanket. The mother checked on the child at 1:45 PM and the child was fine. At 3:00 PM, the mother checked on the child and found her to be unresponsive. The mother carried the child into the living room to tell the father. The father performed CPR while the mother called 911. The mother stated the child's nose began to bleed while the father performed CPR. The mother was interviewed regarding the alleged domestic violence multiple times throughout the investigation and denied she and the father physically fought.

The father was interviewed and reported the child had been vomiting more frequently than normal and that she was fussy. He reported that the child would vomit after every feeding and told the mother to take the child to the pediatrician; however, she would say that the child was fine and that she knew what she was doing. On the day of the death, the father checked on the child between 1:00 PM – 2:00 PM and the child was moving and breathing. Later the mother checked on the child and the child was unresponsive.

The 5-year-old was interviewed and did not provide information regarding the death. There were no concerns reported.

ACS gathered collateral information from the maternal and paternal grandmothers, the pediatrician, the 2-year-old sibling's mother, the 5-year-old sibling's father, the school, and the community-based agency. The pediatrician and school staff did not have concerns. The grandmothers both expressed concerns for domestic violence and arguing in the presence of the children. The sibling's mother expressed concern for domestic violence as she had been a victim of the father. The sibling's father also had concerns of the father being physically violent toward the mother.

On 01/08/24, the parents were interviewed, again denying any domestic violence. The mother denied the child was vomiting. The father reported the child only spit up when being burped. The mother provided various reasons as to why the sibling was absent from school. ACS provided a referral for Early Intervention.

ACS determined the allegations and referred the family to services. The family was engaged in services through a community-based agency at the time of this writing. The investigation was closed timely on 02/12/24.

## 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)?**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 |
|---|---|---|---|
| 066887 - Deceased Child, Female, 2 Month(s) | 066889 - Father, Male, 23 Year(s) | DOA / Fatality | Unsubstantiated |
| 066887 - Deceased Child, Female, 2 Month(s) | 066888 - Mother, Female, 23 Year(s) | DOA / Fatality | Unsubstantiated |
| 066887 - Deceased Child, Female, 2 Month(s) | 066889 - Father, Male, 23 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066887 - Deceased Child, Female, 2 Month(s) | 066888 - Mother, Female, 23 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066890 - Sibling, Female, 5 Year(s) | 066889 - Father, Male, 23 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066890 - Sibling, Female, 5 Year(s) | 066888 - Mother, Female, 23 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066891 - Sibling, Female, 1 Year(s) | 066889 - Father, Male, 23 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 066891 - Sibling, Female, 1 Year(s) | 066888 - Mother, Female, 23 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?** | ☒ | ☐ | ☐ | ☐ |
| **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?** | ☒ | ☐ | ☐ | ☐ |

**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:**<br>The family accepted preventive services through a community-based agency. | | | | |

**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:**<br>The children did not need to be removed. | | | | |

## 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** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Additional information, if necessary:**
A services case was opened for the family. ACS documented the 5-year-old sibling received Early Intervention 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?** Unable to Determine
**Explain:**
The parents were provided with referrals for bereavement services; however, it remained unknown if the 5-year-old sibling engaged in the service.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Unable to Determine
**Explain:**
The parents were offered bereavement services and funeral assistance. The mother declined the services. The father accepted the services. It remained unknown if he engaged in counseling services.

## 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

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 03/03/2022 | Sibling, Female, 7 Months | Father, Male, 22 Years | Inadequate Guardianship | Unsubstantiated | No |

**Report Summary:**
An SCR report alleged that on 02/28/22 at 9:30 AM, the father strangled and punched the then 7-month-old sibling's mother while she was holding the sibling. That mother sustained injuries as a result of the assault. The sibling did not sustain injures.

**Report Determination:** Unfounded | **Date of Determination:** 04/15/2022

**Basis for Determination:**
The allegation was unsubstantiated. The Investigation Conclusion Narrative stated that the sibling's mother did not have

bruises and she called 911 three days after the alleged assault. The record reflected that mother threatened to call ACS should the father not leave his then partner, the subject child's mother. Law enforcement did not observe injuries. The collaterals reported the allegations would be "extremely out of character" and they did not believe the father assaulted the sibling's mother.

**OCFS Review Results:**
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed timely. Home visits were made, and the family and collateral contacts were interviewed. The allegation was appropriately determined. Safe sleeping information was provided to that mother.

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

## 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 is no known CPS history outside of New York.

## 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