Child Fatality Report

Report Identification Number: AL-17-005

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

Issue Date: Jul 17, 2017

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		
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
CPR-Cardiopulmonary Resuscitation		
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	

Case Information

Report Type: Child Deceased
Age: 4 month(s)
Jurisdiction: Clinton
Gender: Male
Date of Death: 01/31/2017
Initial Date OCFS Notified: 01/31/2017

Presenting Information

SCR report dated 1/31/17 alleged two adults had been babysitting the 4-month-old SC in their home for the past 4 or 5 months, two days a week for approximately 9 hours at a time. On 1/31/17, SC's parental guardian dropped the SC off at the caregivers' home and on 2 different occasions during the morning, the male caregiver laid the SC down on an adult sized bed which also had a blanket on it. Around 11:05am, the other (female) caregiver came home from work and checked on the SC, finding him unresponsive. The male caregiver was in the kitchen/living room area at that time. The female caregiver called 911 and the SC was transported to a hospital, where he was pronounced deceased. The SC did not have any visible injuries. The male caregiver had 3 children of his own, ages 12, 10, and 10. Those other children were not present at the time and their roles were unknown. The SC's parental guardians had unknown roles at the time of the report.

Executive Summary

Clinton County Department of Social Services (CCDSS) received an SCR report on 1/31/17 regarding the death of the 4-month-old male SC. It was alleged a male caregiver (referred to as CG1) and female caregiver (referred to as CG2), babysitters of SC only, were responsible for SC's death after he was placed to sleep in an unsafe environment (on an adult bed with a blanket). CCDSS added allegations against SC's guardians (referred to as G1 and G2), due to the suspicious nature of the death and the fact they were sole caregivers up until SC was dropped off at the babysitters' home.

CCDSS learned SC's birth parents had a pre-arranged guardianship agreement with a relative (G1) prior to his birth. Immediately upon SC's birth, G1 and G2 took guardianship with the ultimate goal of adoption. The adoption was never finalized prior to SC's death. CCDSS interviewed BM and BF and assessed the safety of their children despite the fact that SC had no contact with them. CCDSS prioritized the safety of the OC who resided part-time with CG1 and CG2. Those children, referred to as OC1 and OC2 (twins, age 10) and OC3 (age 12) were CG1's children and resided with him and CG2 when they were not with their mother. OC4 (age 10) was CG2's child and resided with her and CG1 when he was not with his father. OC1, OC2, and OC3 were in the home on the date of the fatality and saw the SC alive before they went to school. OC4 was not present on the date of the fatality. SC had no SS in his home.

CCDSS coordinated the investigation with LE. Criminal charges were pending when the case closed. CCDSS learned CG1's description of events on the date of the fatality: SC was dropped off, and CG1 brought SC with him on two different occasions that morning while he drove his children to school. Later CG1 put SC on his stomach to nap on an adult bed on top of a folded comforter. He did not check on SC for about an hour, at which time CG2 returned from work and found SC face-down in the comforter, unresponsive. CG1 called 911 while CG2 performed CPR.

When initially interviewed on 1/31/17, the 3 OC corroborated the SC was with them on their rides to school. In a subsequent interview later the same day, it was learned CG1 had told them to lie and a different version was disclosed: CG1 left SC alone with OC1 and OC2 while he brought OC3 to school, then returned home to pick up OC3 for school, at which time he left SC home alone. The OC stated this happened regularly; CG1 denied this. A safety plan was made with the family that CG1 and CG2 not have any unsupervised contact with their children. Family members helped facilitate the plan. The BM of CG1's children filed in Family Court, resulting in full custody to that BM and an order of protection for the children. A court-ordered investigation was initiated, and although concerns for the OC were known, CCDSS unfounded that report.

CCDSS found CG2 had no knowledge that lack of supervision was a regular occurrence. CCDSS learned the SC was

not in any distress at the time G2 dropped him off, nor was there evidence G1 or G2 knew or should have known CG1 regularly left SC unattended. CG2, G1 and G2 were found not to have a direct role in the events leading up to the fatality. For these reasons, CCDSS unsubstantiated allegations against them; however, all 4 caregivers confirmed there were no safe sleep provisions for SC while at the babysitters' home. All 4 had knowledge that while at that home, SC regularly slept in an unsafe environment. With no safe sleep provisions provided, they all failed to provide a minimum degree of care. CCDSS appropriately substantiated all allegations against CG1 regarding the SC, as well as the added allegations of IG for the 3 OC.

Though the autopsy report was pending, CCDSS gathered some credible evidence to link the elements of maltreatment to causation of the death. Bereavement and funeral assistance services were offered to G1 and G2, and MH information was provided to parents of the OC.

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:
All safety and risk assessments were timely and accurate.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The level of casework was commensurate with case circumstances, and the decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Evidence indicated G1, G2 and CG2 were aware of the unsafe sleep environment at the babysitter's home, consistent during the regular care of the SC. No caregiver rectified the situation and SC subsequently died, though these persons were UNF.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	CCDSS will take into consideration all information gathered during the investigation when applying the circumstances to the definition(s). In response, CCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days identifying what action CCDSS has taken, or will take, to address this. If a PIP is currently in place, CCDSS will review the plan and revise as needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/31/2017 **Time of Death:** 12:10 PM

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

County where fatality incident occurred: Clinton
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to 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? No - but needed
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
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Month(s)
Deceased Child's Household	Other Adult - SC's Guardian	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Other Adult - SC's Guardian	Alleged Perpetrator	Male	35 Year(s)
Other Household 1	Other Adult - SC's babysitter	Alleged Perpetrator	Male	39 Year(s)
Other Household 1	Other Adult - SC's babysitter	Alleged Perpetrator	Female	29 Year(s)

Other Household 1	Other Child - Male babysitter's child	Alleged Victim	Male	10 Year(s)
Other Household 1	Other Child - Male babysitter's child	Alleged Victim	Male	12 Year(s)
Other Household 1	Other Child - Male babysitter's child	Alleged Victim	Male	10 Year(s)
Other Household 1	Other Child - Female babysitter's child	No Role	Male	10 Year(s)
Other Household 2	Other Adult - BM of male babysitter's children	No Role	Female	37 Year(s)
Other Household 3	Other Adult - BF of female babysitter's child	No Role	Male	28 Year(s)
Other Household 4	Father	No Role	Male	22 Year(s)
Other Household 4	Mother -	No Role	Female	27 Year(s)

LDSS Response

Within 24 hours of the report, CCDSS spoke with the source, coordinated with LE, began interviews, reviewed history, and assessed safety of the OC. A safety plan was devised with family members in an effort to mitigate concerns surrounding the death of SC. CCDSS learned information pertaining to guardianship of SC, and determined SC's biological siblings had no contact with him or the subjects, and thus were not in any apparent danger. CCDSS contacted SC's BM and BF, and discussed safety-related topics as well as the death.

CCDSS added allegations against all caretakers of SC, due to their caretaking roles and the suspicious nature of the death; namely, SC was an otherwise healthy child who passed away.

CG1 babysat SC while G1 and G2 worked, as was routine, and G1 and G2 were not present at the time of the fatality. G2 dropped SC off to CG1 that morning, and at that time SC was in no apparent distress, was not suffering from any illness, and had not been given any medications or remedies. CCDSS inquired about drug and alcohol use by all adults, and all denied. There was no evidence to suggest CG1 was impaired at the time of the fatality.

CCDSS learned of inconsistencies in reported sequence of events leading to SC's death between the statements of CG1 and the 3 OC present in the home that day. CG1 reported the last time he saw SC alive was at 10:20am, after he checked on the SC napping, on his stomach, as was typical. He stated SC felt cold due to the temperature in the room, but said he knew SC was breathing. When CG2 returned from work around 11:00am, she found SC unresponsive with his face down in the comforter on top of the bed. CG2 performed CPR as instructed during the 911 call. EMS were not able to revive SC.

CCDSS added the allegation of IG against CG1 for his children. Some credible evidence was found that he left SC alone in the care of OC1 and OC2 on the date of the fatality, as well as alone with OC3 on more than one occasion in the past, and the OC lacked knowledge and abilities regarding infant care. He also left SC alone when he later brought OC3 to school on that date. Such was also the basis for adding the allegation of LS against CG1 regarding SC. SCDSS found LS was a possible contributing factor to SC's death.

G1 and G2 acknowledged awareness of safe sleep practices. They described recently putting SC on his stomach to sleep and kept a blanket and stuffed animal in his crib at home. G1, G2, CG1, and CG2 all corroborated that regular sleep practice at the babysitter's home was on the adult sized bed, as all knew there was no safe alternative in the home. CCDSS concluded G1, G2 and CG2 played no role in the circumstances of the death, as they were not the ones who placed SC to sleep in such position the day SC died. CCDSS determined G1 and G2 had no reason to suspect SC would be left unsupervised in CG1's care, or was otherwise inadequately cared for. Despite this conclusion, all 4 caregivers failed to provide SC with a minimum degree of care by not providing him with a safe environment in which to sleep at the babysitters' home. This link was not reflected in the determination.

A court-ordered investigation (COI) was initiated on 2/23/17 concerning CG1's children. Their BM filed custody and

family offense petitions. CCDSS spoke with all relatives on that case and thoroughly documented all discussions. The report was unfounded against all alleged subjects, though the evidence mentioned above in the fatality investigation satisfied the definition of some credible evidence as it pertained to his children in the COI. The information regarding his children was known to CCDSS, and the Investigation Conclusion did not speak to the reason for the inconsistencies in determinations despite the same evidence. The result of Family Court was full custody awarded to their BM, and a no contact order of protection was issued for the children against CG1, further evidencing concerns for CG1's care of his children.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Unknown
Comments: Although it is unclear if the investigation was conducted by an MDT, CCDSS worked closely with LE and adhered to previously approved protocols for joint investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in Clinton County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
036179 - Other Child - Male babysitter's child, Male, 12 Year(s)	036177 - Other Adult - SC's babysitter, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
036180 - Other Child - Male babysitter's child, Male, 10 Year(s)	036177 - Other Adult - SC's babysitter, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
036181 - Other Child - Male babysitter's child, Male, 10 Year(s)	036177 - Other Adult - SC's babysitter, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
037462 - Deceased Child, Male, 4 Month(s)	036177 - Other Adult - SC's babysitter, Male, 39 Year(s)	Lack of Supervision	Substantiated
037462 - Deceased Child, Male, 4 Month(s)	038361 - Other Adult - SC's Guardian, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
037462 - Deceased Child, Male, 4 Month(s)	036177 - Other Adult - SC's babysitter, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
037462 - Deceased Child, Male, 4 Month(s)	036178 - Other Adult - SC's babysitter, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
037462 - Deceased Child, Male, 4 Month(s)	038362 - Other Adult - SC's Guardian, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
037462 - Deceased Child, Male, 4 Month(s)	036177 - Other Adult - SC's babysitter, Male, 39 Year(s)	DOA / Fatality	Substantiated
037462 - Deceased Child, Male, 4 Month(s)	036178 - Other Adult - SC's babysitter, Female, 29 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

Additional information:

CCDSS spoke with all necessary familial and collateral contacts. Interviews with everyone on the case were conducted face-to-face, as were several collateral contacts.

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 safety 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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Explain as necessary:
There was no removal necessary for any of the OC. Safety interventions that were implemented sufficiently protected the surviving children from immediate or impending danger of serious harm.

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: Other Family Court (Including Article 6 Custody/Guardianship

Date Filed:	**Fact Finding Description:**	**Disposition Description:**
02/22/2017	There was not a fact finding	There was not a disposition
Respondent:	None	
Comments:	A court-ordered investigation was ordered after petitions for custody and family offenses were filed by the mother of OC1, OC2 and OC3 against their father, CG1 (the caregiver responsible for the death of the SC). This was in response to the mother's concerns surrounding the fatality as well as additional concerns for his parenting over the years. As a result, their mother was awarded full custody and an order of protection for supervised contact only was put into place against CG1 regarding those children. It is likely that their custody appearances remained an ongoing matter.	

Have any Orders of Protection been issued? Yes

From: 02/22/2017	**To:** Unknown

Explain:
An order of protection was put into place against CG1 regarding his 3 children, filed by their mother in response to her concerns for the events surrounding the fatality. CG1 was ordered to have no unsupervised contact with his children, and

their mother was awarded full custody. It is unknown how long the order was to remain in effect.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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:
Bereavement counseling and assistance with funeral arrangements were offered to G1 and G2. Parents of the OC were offered information on mental health services for them. Family members assisted in the safety plan to protect the children during the investigation.

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:
Parents were given information on mental health services for their children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Information on bereavement services and funeral assistance was provided to the parents/guardians of the SC. It is unable to be determined whether those services were utilized.

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? N/A
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS history found involving the SC, OC, or CG1. G1, G2 and CG2 had no CPS history as alleged subjects.

Known CPS History Outside of NYS

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

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐ Yes ☒ No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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