Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-21-004

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

Issue Date: Jul 26, 2021

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 12 year(s)
Jurisdiction: Ontario
Gender: Male
Date of Death: 02/01/2021
Initial Date OCFS Notified: 02/01/2021

Presenting Information

Ontario County Department of Social Services (OCDSS) received a report from the SCR alleging the 12-year-old subject child had asthma and required an inhaler and nebulizer treatment. The mother, grandmother, and father were aware, but failed to ensure the subject child had necessary medication. As a result, on 2/1/21, the subject child had an asthma attack from which he was unable to recover. The mother attempted to pick up an inhaler for the subject child during the asthma attack while the grandmother stayed home with the subject child and his siblings, ages 14, 8, 4, and 2 years old. The asthma attack progressed and the mother advised the grandmother to call 911. Upon instruction by the 911 operator, the grandmother began CPR on the subject child. When emergency medical services arrived, the subject child was lying at the front door where he had been attempting to catch his breath with the cold air from outside. The subject child was transported to the hospital and pronounced dead.

Executive Summary

This fatality report concerns the death of the 12-year-old male subject child that occurred on 2/1/21. A report was made to the SCR on the same date with concerns the mother, father, and grandmother failed to seek medical treatment for the child, which resulted in his death. He resided at home with his mother, father, grandmother, and siblings ages 14, 8, 4, and 2 years old.

Through a joint investigation with law enforcement, it was learned the subject child had an asthma attack on the evening of 2/1/21. The mother reported the child woke that morning struggling to breathe and was wheezing. The child completed a nebulizer treatment and began his schoolwork. The subject child continued to struggle breathing throughout the day. The mother went to the store to pick up an over-the-counter remedy for the subject child around 6:30PM. The mother left the subject child and siblings at home with the grandmother when she went out. The mother was on the phone with the 14-year-old sibling when the subject child collapsed shortly after 7:00PM. The grandmother notified the mother, called 911 and began CPR on the subject child. First responders arrived and transported the child to the hospital where he was pronounced dead at 9:04PM.

OCDSS interviewed family members and pertinent collateral sources. It was learned that the family was aware of the severity of the subject child’s asthma and knew the importance of the child’s medication management and appointments for the child’s allergy shots. The subject child and siblings were seen regularly by their pediatrician and were up to date on immunizations and well-child visits. The medical records reflected the family was not compliant with the subject child's asthma medications. The allergist records corroborated the concern for non-compliance. The pediatrician described the subject child as “severely asthmatic” and reported the parents were dependent on the subject child being responsible for his own medications. The pediatrician reported that, due to the subject child’s age and diagnosis of autism, he was not responsible enough to take his own medication.

An autopsy was not performed due to the conditions surrounding the death. Law enforcement determined there was no criminality in the death. OCDSS indicated the allegations of Inadequate Guardianship, Lack of Medical Care, and DOA/Fatality against the mother, father, and grandmother as the family was aware of the severity of the child’s asthma and did not obtain necessary medication and were not compliant with appointments for allergy shots. The mother, father, and grandmother expected the subject child to be responsible for administering his own medication despite his age and diagnosis of autism. Medical professionals did not believe it was realistic to have such expectations for the subject child. OCDSS also indicated the parents and grandmother for Inadequate Food/Clothing/Shelter regarding the subject child and

siblings. The home was in a deplorable state at the time of the subject child's death. A safety plan was made for the siblings to stay with alternate caregivers until the home could be cleaned up and deemed safe. OCDSS filed an Article 10 Neglect Petition against the parents and grandmother for the siblings as a result of the condition of the home. OCDSS determined filing a Neglect Petition was necessary as the family needed additional support and oversight regarding the condition of the home as well as the mental health concerns for the siblings. Preventive Services were in place at the time of this writing and the family was compliant with providers.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The siblings were assessed to be safe in the parents' care. The case was indicated and remained open for Preventive Services.

Was the decision to close the case appropriate? N/A

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:
Casework activity was commensurate with best casework practice and there was detailed supervisory consultation throughout the case.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/01/2021 **Time of Death:** 09:04 PM

Time of fatal incident, if different than time of death: 07:20 PM

County where fatality incident occurred: Ontario
Was 911 or local emergency number called? Yes
Time of Call: 07:20 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: having an asthma attack

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **N/A**

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	12 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	70 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	14 Year(s)

LDSS Response

OCDSS initiated their investigation upon receipt of the SCR report on 2/1/21. They reviewed SCR history, spoke to law enforcement, and reviewed records from first responders related to the incident.

Immediately upon learning of the fatality, OCDSS responded to the family's home and offered condolences and information on bereavement services. OCDSS interviewed the mother, father, and grandmother at their home. The mother reported the subject child had chronic asthma and was struggling with symptoms of asthma during the day of 2/1/21. The mother went to the store around 6:30PM to retrieve an over-the-counter remedy for the asthma symptoms. On her way home from obtaining medication, the mother was on the phone with the sibling and received a frantic message from the grandmother that the child had collapsed, and first responders were en route. The grandmother was administering CPR while she awaited the arrival of first responders.

After speaking with the mother, OCDSS interviewed the grandmother. The grandmother corroborated information received from the mother. The grandmother recalled being home with the subject child and siblings while the mother went to the store. The grandmother reported the child had been struggling with symptoms related to asthma for the entire day. While the mother was at the store, the grandmother told the subject child to go outside for some fresh air in hopes that he would be able to breathe better. Upon going outside, the subject child collapsed. The grandmother called 911 and began CPR while awaiting the arrival of first responders. The child was transported to the hospital where he was pronounced deceased.

The father was at work when the subject child had the asthma attack. He arrived home just after the ambulance left for the hospital and was attempting to get to the hospital when he was notified the child had passed away. The father reported the subject child had struggled with asthma since he was 2-3 years old and was on a host of medications.

OCDSS spoke to numerous collateral sources including family members, hospital staff, and first responders. OCDSS received and reviewed records from the pediatrician, law enforcement, EMS, and the hospital. Safety was established within the required timeframe, and all other documentation was commensurate with case circumstances. Safety assessments and required reports were completed accurately and within the required time frame. OCDSS completed all necessary casework activity prior to making an accurate determination of allegations, then opened a Preventive Services case to offer additional support to the family.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: OCDSS adhered to previously approved protocols for joint investigations by collaborating with law enforcement and notifying the DA's office of the death.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
057541 - Deceased Child, Male, 12 Yrs	057544 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Substantiated

057541 - Deceased Child, Male, 12 Yrs	057544 - Grandparent, Female, 70 Year(s)	Lack of Medical Care	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057544 - Grandparent, Female, 70 Year(s)	DOA / Fatality	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057543 - Father, Male, 35 Year(s)	Lack of Medical Care	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057543 - Father, Male, 35 Year(s)	DOA / Fatality	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057542 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057542 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057542 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057544 - Grandparent, Female, 70 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057542 - Mother, Female, 34 Year(s)	Lack of Medical Care	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057543 - Father, Male, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057541 - Deceased Child, Male, 12 Yrs	057543 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
057545 - Sibling, Female, 8 Year(s)	057543 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
057545 - Sibling, Female, 8 Year(s)	057544 - Grandparent, Female, 70 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057545 - Sibling, Female, 8 Year(s)	057543 - Father, Male, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057545 - Sibling, Female, 8 Year(s)	057544 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Substantiated
057545 - Sibling, Female, 8 Year(s)	057542 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057545 - Sibling, Female, 8 Year(s)	057542 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
057546 - Sibling, Female, 14 Year(s)	057544 - Grandparent, Female, 70 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057546 - Sibling, Female, 14 Year(s)	057543 - Father, Male, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057546 - Sibling, Female, 14 Year(s)	057542 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
057546 - Sibling, Female, 14 Year(s)	057544 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Substantiated
057546 - Sibling, Female, 14 Year(s)	057543 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
057546 - Sibling, Female, 14 Year(s)	057542 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

057547 - Sibling, Female, 4 Year(s)	057543 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
057547 - Sibling, Female, 4 Year(s)	057544 - Grandparent, Female, 70 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057547 - Sibling, Female, 4 Year(s)	057542 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057547 - Sibling, Female, 4 Year(s)	057544 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Substantiated
057547 - Sibling, Female, 4 Year(s)	057542 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
057547 - Sibling, Female, 4 Year(s)	057543 - Father, Male, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057548 - Sibling, Male, 2 Year(s)	057542 - Mother, Female, 34 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057548 - Sibling, Male, 2 Year(s)	057542 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
057548 - Sibling, Male, 2 Year(s)	057544 - Grandparent, Female, 70 Year(s)	Inadequate Guardianship	Substantiated
057548 - Sibling, Male, 2 Year(s)	057543 - Father, Male, 35 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057548 - Sibling, Male, 2 Year(s)	057544 - Grandparent, Female, 70 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
057548 - Sibling, Male, 2 Year(s)	057543 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

Relevant collateral sources were interviewed.

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:
OCDSS gathered sufficient information to assess for risk of the siblings. OCDSS determined there were factors that placed the siblings at risk of harm and implemented a safety plan to offer support to the family. OCDSS filed an Article 10 Neglect Petition due to the conditions of the home and opened a Preventive Services case to provide the family with additional support.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: There was no removal of the surviving siblings.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
04/13/2021	There was not a fact finding	There was not a disposition
Respondent:	057542 Mother Female 34 Year(s)	
Comments:	An Article 10 Neglect Petition was filed against the parents and grandmother regarding the surviving siblings. It was determined the unsanitary conditions of the home aggravated the allergy and asthma symptoms of the subject child. The parents also did not comply with the primary care physician's recommendations for medication with regard to the subject child.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐

Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☒	☐	☐	☐	☐	☐	☐

Other, specify: Preventive Services

Additional information, if necessary:
OCDSS offered services to the family related to bereavement and mental health counseling. Preventive Services were provided in order to give the family additional support following the death.

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? Yes
Explain:
OCDSS provided Preventive Services to the siblings following the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS provided referrals for community-based bereavement and mental health counseling as well as Preventive Services to the parents and grandmother.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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

A report from 2014 was indicated against the father for lack of supervision and inadequate guardianship regarding the then 2-year-old sibling.

Known CPS History Outside of NYS

There was no known 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