



Report Identification Number: NY-17-065

Prepared by: New York City Regional Office

Issue Date: Dec 20, 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	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		



Case Information

Report Type: Child Deceased
Age: 3 month(s)

Jurisdiction: Bronx
Gender: Male

Date of Death: 06/28/2017
Initial Date OCFS Notified: 06/28/2017

Presenting Information

The 6/28/17 SCR report alleged that on 6/28/17 at approximately 3:45 AM, the 3-month-old SC was found unresponsive by the SM. The SC was co-sleeping with the parents at the time. The SM last observed the SC alive and well at approximately 12:30 AM on 6/28/17. The SM attempted CPR on the SC and called 911. On 6/28/17, the SC was pronounced dead at 4:29 AM at Jacobi Medical Center. The cause of death was unknown at the time and was therefore deemed suspicious in nature. The role of the 8-year-old SS was unknown.

Executive Summary

This 3-month-old male SC died on 6/28/17. As of 12/20/17, NYCRO had not yet received an autopsy report.

The allegations of the 6/28/17 SCR report were DOA/Fatality and IG of the SC by the parents.

The Specialist interviewed the parents regarding the circumstances leading to the SC having been found unresponsive on the incident date. Per the parents' account, at about midnight, the SC woke up for a feeding. The SF last saw the SC alive being fed in the arms of the SM. The SF then went to sleep in his bedroom. At approximately 3:45 AM, the SM woke up in the bed and observed the SC was under her arm. The SM alerted the SF that the SC was not breathing. The parents alternated giving the SC CPR. The SM called 911. Two ambulances arrived at the case address and EMS performed CPR on the unresponsive SC. EMS continued CPR on the SC and escorted the SC and parents to the hospital. The MGM and SS were escorted to the hospital in the second ambulance. Upon the SC and the parents' arrival in the hospital, the ER staff continued resuscitative measures; however, shortly thereafter the parents were informed that the SC died.

The family resided in a two-bedroom apartment. The parents shared a bedroom with the SC. The room included a queen-sized bed and a bassinet in which the SC slept separately. Connected to the SC' bassinet, ACS observed the required oxygen machine the SC was prescribed due to his medical condition. The SS and the MGM shared the second bedroom and ACS observed the sleeping arrangements were appropriate. The home was observed to have in place window guards and a working smoke alarm and carbon monoxide detector. The home appeared safe.

During the investigation, the Specialist made relevant contacts and sufficient face-to-face contact with the parents, SS and MGM in the home. The Specialist obtained relevant information from significant collateral contacts. There were no DV incidents regarding the parents. Attempts were made to visit the SF's three minor children. The family was cooperative and receptive of offered services. On 6/28/17, ACS opened the preventive services case. ACS offered the parents services and made a referral for the SF to the Credentialed Alcoholism and Substance Abuse Counselor (CASAC) based on a prior drug arrest and conviction. The parents accepted burial assistance and declined other services. The SF did not attend the scheduled CASAC appointment. On 8/1/17, the SS received services in school.

On 10/13/17, ACS unsubstantiated all the allegations of the 6/28/17 report on the basis that the information gathered from collateral contacts reflected there was no credible evidence of abuse/maltreatment. ACS added that the parents were knowledgeable of the SC's medical diagnosis and the required medical treatment.

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

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:

N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS did not enter Progress Notes contemporaneously. There were a significant number of Progress Notes dated 6/28/17 through 7/31/17 that were entered on 9/5/17, 9/7/17 and 9/20/17.
Legal Reference:	18 NYCRR 428.5
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	ACS did not complete the 30-Day Fatality Report within the required timeframe. The SCR report was received on 6/28/17. On 8/3/17, ACS completed/approved the 30-Day Child Fatality Report.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this



fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Issue: A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.

Summary: ACS did not complete the 24-hour Fatality Report within the required timeframe. The SCR report was received on 6/28/17. On 6/30/17, ACS completed/approved the 24-Hour Fatality Report.

Legal Reference: CPS Program Manual, VIII, B.1, page 2

Action: ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/28/2017

Time of Death: 04:29 AM

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

Unknown

County where fatality incident occurred:

Bronx

Was 911 or local emergency number called?

Yes

Time of Call:

03:58 AM

Did EMS respond to the scene?

Yes

At time of incident leading to death, had child used alcohol or drugs?

N/A

Child's activity at time of incident:

Sleeping

Working

Driving / Vehicle occupant

Playing

Eating

Unknown

Other

Did child have supervision at time of incident leading to death? Yes

Is the caretaker listed in the Household Composition? Yes - Caregiver 1

At time of incident supervisor was:

Drug Impaired

Absent

Alcohol Impaired

Asleep

Distracted

Impaired by illness

Impaired by disability

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	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	75 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)

LDSS Response

On 6/28/17, LE informed ACS the home was deemed a crime scene. Photographs of the home, the SC’s feeding pillow, last bottle and formula were vouchered at the direction of the ME.

The Specialist interviewed the parents separately. The SF said the SC was born premature during the eight month of gestation and had numerous respiratory challenges. Since birth, the SC had three periods of hospitalization, five medical procedures, and required oxygen. The SM recalled she fed the SC 2oz of formula on 6/28/2017, at about 12:30 AM. She said she sat with the feeding pillow around her and the SC was in her left arm. She usually burped the SC in the upright position due to the SC's issues with digestion; however, the SM was uncertain about the exact time she fell asleep. The SM recalled she woke up and saw the SC was face up, eyes closed and head titled towards her next to the pillow. The parents received safe sleep education at the hospital. The parents denied the existence of mental health, DV or drug or alcohol abuse in the home. Both parents reported the SF was asleep in the same bed at the time of the incident. There were no inconsistencies in the parents’ statements. Although the SM revealed she fell asleep while feeding the SC in the parents’ bed, it was unclear if the SM’s behavior was regularly practiced.

The Specialist interviewed the MGM who said the SF came in her bedroom to tell her the SC was not breathing. The MGM denied the parents had a DV relationship or drug and alcohol issues. The PGM stated the SF called her at approximately 4:20 AM to inform her the SC was not breathing and the family had called 911. The grandparents had no concerns regarding the care the parents provided the SC and SS.

On 6/28/17, the attending physician said the SC arrived at the hospital in cardiac arrest. CPR and other medical interventions were provided to the SC. The SC had no marks or bruises on his body except for a scar that was the result of a medical procedure. The SC was diagnosed with a medical condition at birth and had received primary care at the hospital.

According to the family’s neighbors, there were no concerns regarding the care and safety of the children in the home. The neighbors denied they heard or observed incidents that involved the family.

On 6/28/17, the Specialist visited the home and observed and engaged the SS. The SS was interviewed separately from the parents. The SS had no observable marks/bruises, and did not require immediate medical attention. The home was free of any safety concerns or hazards, and the family had an adequate supply of provisions. The SS informed ACS the SC was sick. The SS observed the parents and the MGM administer oxygen to the SC the via a machine. On the incident date, the SS recalled she heard the SF knock on the bedroom door and speak with the MGM. The SS was instructed by the MGM to remain in the room. The SS did not observe the SC unresponsive. The SS denied she witnessed drug use, alcohol use or DV by adults in the home.

On 6/29/2017, the parents, MGM and PGM attended a child safety conference (CSC) at the LDSS office. The CSC participants discussed concerns of the SF’s drug conviction. ACS referred the SF for CASAC and offered the



bereavement, burial and PPRS services the family.

According to the Dr., the SC was present for all scheduled medical appointments, including specialized care. The SC and SS' immunizations were up to date.

On 6/30/17, a home visit was made to one of the SF's three minor children. The 14-year-old child was observed and it was determined that he received adequate care.

On 8/28/17, ACS obtained EMS record and noted the 911 call was received at 3:58 AM of an unresponsive child. EMS arrived at the home at 4:04 AM and departed 4:16 AM, and arrived in the hospital at 4:24 AM.

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)?No

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

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

Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039301 - Deceased Child, Male, 3 Mons	039304 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
039301 - Deceased Child, Male, 3 Mons	039304 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
039301 - Deceased Child, Male, 3 Mons	039305 - Father, Male, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
039301 - Deceased Child, Male, 3 Mons	039305 - Father, Male, 38 Year(s)	DOA / Fatality	Unsubstantiated

CPS Fatality Casework/Investigative Activities

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



Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

ACS did not enter Investigation Progress Notes contemporaneously. A significant number of progress notes dated 6/28/17 through 7/31/17 were entered on 9/5/17, 9/7/17 and 9/20/17.

Fatality Safety Assessment Activities

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

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------	-------------------------------------	--------------------------

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

History Prior to the Fatality

Child Information

- Did the child have a history of alleged child abuse/maltreatment? No
- Was there an open CPS case with this child at the time of death? No
- Was the child ever placed outside of the home prior to the death? No
- Were there any siblings ever placed outside of the home prior to this child's death? No
- Was the child acutely ill during the two weeks before death? 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

The SM had no CPS history more than three years prior to the fatality.

The SF was known in one report dated 7/1/07. The allegations of the report were IG, IFCS and LS of the SF two other children. On 8/16/07, the allegations were unsubstantiated.

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