Child Fatality Report

Report Identification Number: NY-20-110

Prepared by: New York City Regional Office

Issue Date: Jun 08, 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: 1 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 12/06/2020
Initial Date OCFS Notified: 12/07/2020

Presenting Information

The SCR report alleged on 12/6/20, the mother was co-sleeping with the one-month old female subject child on the same bed (futon). At about 3:00AM, the mother fed the subject child and then fell asleep with her on the futon. At 5:00AM, the mother awoke and found the subject child unresponsive next to her. The mother called 911 for emergency medical assistance and initiated CPR. EMS arrived at the home, and intubated the subject child on the way to the hospital. At 10:28AM, the subject child was transferred to another hospital. While at the second hospital, the subject child had two episodes of cardiac arrest and was pronounced dead on 12/6/20 at 7:57PM.

Executive Summary

The one-month-old female subject child died on 12/6/20. As of 5/22/21, NYCRO had not received a copy of the autopsy report; therefore, the cause and manner of death were not known.

At the time of the fatality the subject child resided with her mother and maternal grandparents. The mother had a previous child fatality and an SCR report was registered on 12/20/19. OCFS NYCRO issued a report regarding the previous fatality. There were no surviving siblings or other children in the household.

According to the ACS's documentation, at about 3:00AM on 12/6/20, the mother fed the subject child and intended to change the child's diaper, but "passed out" and awoke at 5:00AM. The mother saw the subject child had rolled over and her face was toward the couch's cushion; the child was unresponsive. The maternal grandmother called 911 and the operator provided instructions on how to perform CPR on the subject child. The mother performed CPR with the assistance of a neighbor. EMS arrived about five minutes later. The subject child was transported to the local hospital, hen transferred to another hospital for a higher level of care. The subject child was later pronounced dead at the second hospital.

EMS information reflected the 911 call was received at 5:50AM and the ambulance arrived at the home at 5:55AM. The ambulance arrived at the hospital at 6:10AM.

ACS learned the subject child's usual sleep place was a bassinet in the mother's room, and observed the mother had a bassinet, a crib, and a side sleeper for the subject child. The mother had been provided information regarding safe sleep information following the death of her child in 2019. The mother denied drinking alcohol, using any substance, or taking any medication. However, law enforcement reported the mother had been drinking the night before, but noted the mother said she was not intoxicated when she placed the subject child next to her on the futon/couch..

ACS made contact with family members, law enforcement, the Medical Examiner, and other medical personnel.

The Medical Examiner reported a reenactment was completed with the family regarding the child's position when the subject child was found and it was consistent with the mother's statement. There were no unexplained injuries to the child. There was evidence of medical intervention. The Medical Examiner did not provide any preliminary statements regarding the cause and manner of death.

Law enforcement indicated their investigation would remain open pending the receipt of the final report from the Medical Examiner, and suggested that the mother could be charged with Negligent Homicide since this was the second fatality

involving the mother and with the same circumstances. As of the writing of this report, no arrests had been made.

The family had no concerns about the level of care the mother had provided to the subject child.

On 2/5/21, ACS substantiated the allegation of Inadequate Guardianship of the subject child by the mother. ACS documented there was some credible evidence the mother failed to provide an appropriate level of care that met commonly accepted societal norms. To support the decision, ACS further documented the mother had a prior child fatality due to co-sleeping. When the subject child in the current report was born, the mother was provided with instructions on safe sleep, but the mother failed to follow the guidelines. In addition, based on law enforcement's investigation, the mother had been drinking the night before. The mother also said she "passed out" for about two hours and when she awoke the subject child was unresponsive.

ACS unsubstantiated the allegation of DOA/Fatality by the mother on the lack of credible evidence. ACS documented the autopsy report had not yet been completed by the ME, so the cause and manner of death were not known.

The mother declined burial assistance, and the father declined all services. ACS discussed bereavement counseling and provided referrals.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
    - **Safety assessment due at the time of determination?** 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:
Sufficient information was gathered to make determination for all allegations on the intake report.

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 activity, which included contact with the family and others from the receipt of the report through case conclusion, was commensurate with the case circumstances.

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: 12/06/2020 **Time of Death:** 07:30 PM

Time of fatal incident, if different than time of death: 05:00 AM

County where fatality incident occurred: Bronx
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 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
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

☐ Distracted ☐ Absent
☒ Asleep ☐ 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	1 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	53 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	60 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Father	No Role	Male	26 Year(s)

LDSS Response

ACS initiated an immediate response to the fatality report by contacting the hospital. At the time of contact, ACS learned the subject child had a history of a medical condition, but there was no indication the death was related to the condition.

The subject child was scheduled to see a medical specialist on 12/18/20, to address the medical condition. Medical personnel reported a review of the child's birth record reflected the subject child was born full term at thirty-nine weeks, and had a three-day stay at the hospital, which was normal. There were no major concerns noted.

On 12/7/20, ACS contacted law enforcement and was informed, as stated by the mother, on 12/6/20, at around 3:00AM she fed the subject child then "passed out" and awoke at around 5:00AM to find the subject child unresponsive. Law enforcement said they would await the autopsy report before a decision regarding any possible arrests was made.

On 12/7/20, ACS contacted neighbors and learned that on the evening of the fatality they heard yelling from the family's home, and when they asked if they could help, the mother said the subject child was not breathing. The neighbors said the maternal grandmother was holding the subject child while she was on the phone with the 911 operator. The neighbors said the maternal grandfather grabbed the subject child, placed the child on the floor, and attempted to perform CPR. The neighbors said they had no concerns for the family.

On 12/7/20, the treating physician stated the subject child was brought in from another medical facility on 12/6/20 in cardiac arrest and was unstable. There was no injury, trauma, or fracture to the subject child's body. According to the mother's account, the subject child awoke at 3:00 AM. The mother fed, then laid the subject child on the futon. The mother placed the child on her back. The mother sat next to the subject child and fell asleep in a seated position. The mother awoke at 5:00 AM and found the subject child unresponsive. The mother reported observing no milk or formula coming from the child's nose or mouth. However, the mother said the subject child was fussy the night before and was ill.

On 12/7/20, the CPS interviewed family members. The mother repeated that the subject child had been fussy since 12/4/20 and believed the subject child might have caught a cold. The mother said the subject child's nose was clogged on 12/5/20, but she had no fever. The mother said the subject child had also vomited after drinking her milk. The mother's statement regarding the incident remained unchanged. However, the mother added that when she awoke, she noticed the subject child had rolled over and her face was towards the couch's cushion. The mother reported that she, along with neighbors, performed CPR until the ambulance arrived. CPS interviewed the mother regarding current or past substance use. The mother denied any substance and alcohol use during the weekend. The mother stated she does not drink alcohol. CPS assessed the home and found no drug paraphernalia or alcohol present. CPS also used the drug assessment checklist and found no indication of substance use. The mother declined burial assistance.

The maternal grandmother said the subject child had never slept with the mother and had always slept in the bassinet. The maternal grandmother did not have any concerns with the care the subject child received from the mother.

The maternal grandfather told CPS he awoke when the mother came to the room with the subject child who was not moving. He said they attempted to perform CPR until EMS arrived. The grandfather said he had not seen the mother co-sleep with the subject child. He also did not have any concerns regarding the level of care provided by the mother.

On 12/7/20, CPS interviewed the paternal grandfather who stated he was unaware of the circumstances of the death. The paternal grandmother stated the she had not observed any issues with the care the mother provided to the subject child, and they did not suspect the mother did anything wrong to cause the deaths of her children.

On 12/8/20, the Medical Examiner said the medical legal investigator completed their report and did a reenactment with the family. The marks on the child's body and other findings were consistent with the medical intervention the subject child received while in the hospital. There were no findings that were consistent with the subject child sustaining an injury. The Medical Examiner also reported the preliminary autopsy was completed but was not ready for release, as consults had been requested and the Office was awaiting the results.

On 12/8/20, the father of the child was contacted, and stated he had no concerns regarding the mother or her care of the subject child. The father declined referrals for bereavement counseling and other services.

On 12/9/20, EMS information reflected the 911 call was received at 5:50AM and the ambulance arrived at the home at 5:55AM. The ambulance arrived at the first hospital at 6:10AM.

Also, on 12/9/20, the CPS completed an assessment of the home and documented the mother had been prepared for the child. The mother had adequate supplies both for herself and the infant. The CPS documented although the home was cluttered it did not pose any danger to the child. Additionally, the CPS also documented the dimensions of the sleep surface where the child was found unresponsive.

Between 12/10/20 and 2/5/21, ACS contacted the service provider with whom the mother was engaged. The service provider reported the mother had requested counseling due to the fatalities; the mother continued to engage in therapy and was doing well. Case documentation reflected ACS continued to contact the Medical Examiner regarding the cause and manner of death. ACS also continued to contact the family regarding services. The parents declined services

On 2/5/21, ACS substantiated the allegation of Inadequate Guardianship of the subject child against the mother. ACS documented the mother failed to provide an appropriate level of care that met commonly accepted societal norms. The mother had a prior child fatality for co-sleeping and was provided counseling and resources regarding unsafe sleep situations for infants. When the subject child was born, the mother was provided with additional instruction on safe sleep; however, mother failed to follow these guidelines which resulted in the death of the subject child.

ACS unsubstantiated the allegation of DOA/Fatality regarding the subject child by the mother on the basis that the autopsy report was not completed so the cause and manner of death were unknown.

The report was indicated and closed as there were no surviving siblings or other children in the household.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056909 - Deceased Child, Female, 1 Mons	056910 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
056909 - Deceased Child, Female, 1 Mons	056910 - Mother, Female, 23 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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:
On 12/8/20, the subject child's father, who was not a subject of the fatality report, was interviewed by phone.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

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:
ACS provided the family with referrals for bereavement counseling. The parents declined 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? N/A
Explain:
There were no surviving siblings or other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother mother declined burial assistance, and the father declined all services.

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? 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 fetal alcohol effects or syndrome
☒ With neither 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)
12/06/2020	Deceased Child, Female, 1 Months	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
The 12/6/20 SCR report alleged on 12/5/20, the mother was co-sleeping with the subject child on a couch in her bedroom. The mother fell asleep with the subject child laying on her side. On 12/6/20, the mother awoke at about 5:50AM and found the subject child was not breathing or responsive. The report alleged the mother was aware she should not be co-sleeping with the subject child but continued to do so. Someone in the home called 911 and the child was rushed to a local hospital. The subject child was resuscitated and was breathing. It was unknown whether the subject had sustained any other injuries as a result. The maternal grandparents and father had unknown roles.

Report Determination: Indicated | **Date of Determination:** 12/16/2020

Basis for Determination:
ACS substantiated the allegations of the report on the basis that the mother failed to provide an appropriate level of care that met commonly accepted societal norms. ACS documented the mother had a prior child for co-sleeping with a child who was under one year old. The mother had been provided counseling and resources. When the subject child was born, the mother was provided with instruction on safe sleep; however, SM failed to follow these guidelines and it resulted in the SC's death.

OCFS Review Results:
ACS initiated the report in a timely manner and established there was a pattern of co-sleeping. ACS also confirmed there were no other children in the home. ACS made the appropriate collateral contacts including contact with hospital personnel. From medical personnel, ACS learned the mother had reported that at about 5:00AM she was sitting on her futon, which could be opened backwards, and drifted off to sleep. The mother said she was sitting upright while the subject child was on her back on the futon. The mother said at about 5:30AM when she opened her eyes, the subject child was still on her back, but the child was unresponsive. The mother said a family member called 911. The mother said she performed CPR with assistance of her neighbor. ACS also learned the subject child had a medical condition. Additionally, there were no marks, bruises, or fractures on the subject child; however, the subject child had blood coming from the nose but this could have been due to CPR. Medical personnel added the subject child did not have any brain activity at the time she was brought to the hospital.

After a thorough investigation, ACS indicated the report.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/20/2019	Sibling, Male, 2 Months	Grandparent, Female, 52 Years	DOA / Fatality	Unsubstantiated	No

Sibling, Male, 2 Months	Grandparent, Female, 52 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 2 Months	Grandparent, Male, 59 Years	DOA / Fatality	Unsubstantiated
Sibling, Male, 2 Months	Grandparent, Male, 59 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 2 Months	Mother, Female, 23 Years	DOA / Fatality	Unsubstantiated
Sibling, Male, 2 Months	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated

Report Summary:
The SCR report alleged on 12/19/19, the mother and 2-month-old child went to sleep in the same bed. The mother often slept in the same bed as the child and put her arm around him. On 12/20/19 at 2:00AM, the mother checked the child and he appeared well. The mother awoke later and found the child unresponsive. The mother called for emergency medical assistance and when EMS arrived at the home, the technicians found the child cold to the touch. EMS transported the child to the hospital. The ambulance arrived at the hospital at 8:20AM with no pulse. Hospital staff performed CPR on the child for twenty-five minutes and pronounced him dead at 8:45AM.

Report Determination: Indicated | **Date of Determination:** 02/18/2020

Basis for Determination:
ACS substantiated the allegation of Inadequate Guardianship of the child by the mother on the basis of the mother's statements that she had been co-sleeping with the child on the same bed, and when she awoke the child was unresponsive.

ACS unsubstantiated the allegations of DOA/Fatality of the child by the mother and maternal grandparents, and Inadequate Guardianship of the child by the maternal grandparents on the basis of no credible evidence to support the allegations.

OCFS Review Results:
ACS initiated the investigation in accordance with laws, regulations, and policies. The case documentation reflected supervisory involvement throughout the investigation. As per ACS's protocol involving the death of a child under three, ACS held an initial Heightened Oversight Process (HOP) conference on 12/20/19 and a follow-up conference on 1/10/20. ACS completed mental health and domestic violence consults and as a result the family was referred for bereavement counseling. The case documentation also reflected contact with the mother, maternal grandparents, godmother, neighbors, law enforcement, and the pediatrician. These contacts were interviewed separately, and no concerns were noted. The family was referred for community-based bereavement counseling and services. There were no surviving siblings or other children in the household.

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 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