Child Fatality Report

Report Identification Number: NY-17-079

Prepared by: New York City Regional Office

Issue Date: Jan 30, 2018

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: 7 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 08/10/2017
Initial Date OCFS Notified: 08/10/2017

Presenting Information

The 8/10/17 SCR report alleged on the morning of 8/10/17, at an unknown time, the SM fed the male SC, burped him and then placed him face down on his crib. About 30 minutes later the SM found the SC unresponsive. The SC had blood and formula coming from his mouth and nose. The SC drowned in his own vomit and formula. The SC was an otherwise healthy child. The SM called 911 at 11:25 AM. The police responded to the residence at 11:31 AM and shortly thereafter EMS arrived at the residence and transported the SC to the hospital. The SC arrived at the hospital at 11:42 AM. The SC was pronounced dead at 12:07 PM.

Executive Summary

This 7-month-old male SC died on 8/10/17. The ME listed the cause of death as positional asphyxia and the manner of death as an accident (prone and face down in soft bedding in crib). NYCRO received the autopsy report on 1/11/18.

The allegations of the 8/10/17 report were DOA/Fatality and IG of the SC by the SM.

ACS found that on 8/10/17, the SM was at home with the SC and 7-month-old male twin SS. At approximately 11:00 AM, the SM fed the SC an 8-ounce bottle of milk that contained cereal. After the feeding, she burped and placed the SC face down into the bassinet on top of an adult sized pillow and then proceeded to feed the SS. The SM fell asleep while feeding the SS. At approximately 11:30 AM, she awoke and found the SC unresponsive in the same position she had placed him. The SM observed milk and blood streaming from the SC's mouth. The SM dialed 911 and met EMS outside while she left the SS unattended on the bed. EMS performed CPR on the SC. Via ambulance, the SC, SM and the SS were transported to the hospital. The ER staff continued emergency resuscitative measures to no avail. The SC was pronounced dead at 12:07 PM.

The SM, SC, SS and step-father resided in the basement of a private home, where they rented a small room. The family had adequate sleeping arrangements and a sufficient supply of provisions for the SS. The Specialist observed the SS had no visible marks or bruises. The documentation did not include additional details about the home conditions.

ACS opened the Family Service Stage (FSS) of the case on 8/11/17. ACS made a joint home visit (JHV) with PPRS CP on 10/12/17. During the visit, the ACS Specialist and CP observed there were no windows or access to exits, limited lighting and no smoke/carbon monoxide detector in the home. ACS identified the child safety concerns regarding the physical conditions of the family home. The SM and SS temporarily relocated to the home of a friend. On 11/27/17, CP documented the SM returned to the case address.

On 1/2/18, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the SM on the basis that the final ME report determined the SC died of positional asphyxiation and ruled the SC's death an accident. ACS explained that as a result of CPS investigative engagement, the SM admitted she placed the SC face down in the bassinet after the feeding. The SM was aware of safe sleep practices and the manner in which an infant should be placed in the bassinet to sleep. ACS added that the SM contributed to the SC’s demise when she placed him on his stomach and fell asleep, leaving the SC unsupervised in the prone position.

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?** No
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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:
N/A

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:
ACS opened the FSS and the family was referred to Jewish Child Care Association (JCCA). ACS and JCCA conducted a JHV on 10/12/17. ACS and JCCA observed the physical condition of the home was hazardous to the safety of the SS. It was unclear if the SM utilized the EI and DC as ACS and JCCA did not provide follow up information about these service referrals.

Required Actions Related to the Fatality

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

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:	On 8/10/17, the SCR received the fatality report. ACS did not approve the 24-Hour Fatality Report within the required timeframe. ACS approved the fatality report on 8/15/17.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
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:	Timely/Adequate 24 Hour Assessment
Summary:	On 8/10/17, the SCR received a report of DOA/Fatality. The 24-Hour safety assessment was not approved within the required timeframe. On 8/14/17, ACS approved the 24-Hour safety assessment.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
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:	Timely/Adequate Seven Day Assessment
Summary:	On 8/10/17, the SCR received a report of DOA/Fatality. ACS approved the 7-Day Safety Assessment within the required timeframe; however, the ACS did not include information to reflect the hazardous home conditions.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
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:	On 8/10/17, the SCR received the fatality report. ACS approved the 30-Day Fatality Report on 10/9/17. It was not approved within the 30-day timeframe. ACS did not complete or approve a 30-Day Safety Assessment.
Legal Reference:	CPS Program Manual, Chapter 6, K-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.
Issue:	Adequacy of case recording in FASP
Summary:	The comprehensive FASP was due on 11/20/17; however, it was approved on 11/27/17.
Legal Reference:	18 NYCRR 428.6(a)
Action:	JCCA 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. JCCA 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:	Adequacy of case recording in FASP
Summary:	The initial FASP was due on 9/21/17; however, it was approved on 10/21/17.
Legal Reference:	18 NYCRR 428.6(a)
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:	Timely/Adequate Case Recording/Progress Notes
Summary:	ACS did not provide an adequate assessment of the physical conditions of the home. An ACS event regarding child safety assessment occurred on 8/10/17, but was not entered until 10/6/17.
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:	Contact/Information From Reporting/Collateral Source
Summary:	ACS did not obtain information from the Dr. to assess the SS's health needs, developmental stage and confirm immunization history.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
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:	Coordination of Services
Summary:	There was a lack of follow up regarding the SM's participation in PPRS and referral to EI.
Legal Reference:	18 NYCRR 432.2(b)(4)(i) and 432.2 (b)(4)(viii)
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: 08/10/2017 **Time of Death:** 12:07 PM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 11:25 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:

- [x] 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
- [ ] Alcohol Impaired
- [ ] Distracted
- [ ] Impaired by disability
- [ ] Absent
- [x] Asleep
- [ ] Impaired by illness
- [ ] 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	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Month(s)
Deceased Child's Household	Stepfather	No Role	Male	28 Year(s)

LDSS Response

On 8/10/17, the attending Dr. stated the SC arrived via EMS ambulance with the SM and SS at 11:43 AM. ER staff observed the SC was unresponsive, blue around the lips and had a low pulse and low heartbeat. The staff attempted to resuscitate the SC; however, he was pronounced dead at 12:07 PM. There were no visible signs of abuse/maltreatment noted on the SC. The medical record showed the SC and SS were born at 25-weeks of gestation and spent 2 months in Brooklyn Hospital before they were discharged to the SM. The SC was hospitalized at 5 months old for a medical condition and received treatment.

On 8/11/17, ACS interviewed LE who had interviewed the SM at the hospital. Regarding the 8/10/17 incident, ACS learned that the SM fed the SC then placed him on an adult size pillow face down in the bassinet. The SM observed the SC was active and making noise. The SM fed the SS and fell asleep. The SM woke up and found the SC unresponsive and she called 911.

On 8/11/17, the step-father said he assisted the SM with feeding the SC and SS particularly at night. He said the SM was attentive to the twins and he had no concerns regarding the care she provided the twins. The step-father had two children who resided with their BM in a foreign country. He added he was at work at the time of the incident.

On 8/11/17, the BF said he did not have regular visits with the twins but provided financial assistance to the SM. The BF stated he last saw the twins a week prior to 8/10/17 and the twins appeared healthy.

The ACS Specialist visited the home on 8/12/17. The Specialist observed the SM left the SS unattended on the bed when

the SM allowed the Specialist into the home. The Specialist observed the SS's portable bassinet was stored under the SM and step-father's bed. The Specialist counseled the SM and step-father about safe sleep practices. The SS had no visible marks or bruises. ACS observed an adequate supply of provisions for the SS.

The SM provided details about the 8/10/17 incident pertaining to the SC's death. She said the SC was awake when she placed him on his stomach in the bassinet. The SM confirmed she had fallen asleep while feeding the SS in her arms. The SM stated she was educated on safe sleep at Kings County Hospital where she gave birth to the twins. The SM stated the family regularly practiced placing the SC and SS in the bassinet on the stomach on top of an adult sized pillow, and adding cereal to their liquid meal to allow them to sleep. This practice was not at the advisement of the twin's physician. The SM's account of the incident remained consistent.

On 8/15/17, EMS stated upon their arrival to the home the SM was waiting outside holding the SC. The SC was in cardiac arrest with liquid exiting the mouth and nostrils. There were no visible signs of trauma observed on the SC's body.

On 8/16/17, SM attended the Initial Child Safety Conference at the ACS office. The participants discussed safe sleep practices and the adequacy of the SS's sleeping arrangements. ACS offered services and the SM agreed to accept PPRS.

On 10/12/17, ACS and PPRS agency conducted a JHV. The SM agreed to therapeutic services; however, the PPRS CP identified significant safety concerns with the family's living conditions.

On 10/26/17, the SM attended an Elevated Risk Conference at the PPRS agency. The participants discussed the family's strengths and risks concerns. The service plan included the actions to identify an alternative living arrangement for SM and SS.

On 11/6/17, CP visited the home to assess the SM and SS's alternative living arrangement. CP observed no hazardous conditions. The family had adequate provisions and sleeping arrangements for the SS.

On 11/27/17, CP noted the SM returned to the case address due to the SS's inability to sleep well in the alternative living arrangement. No hazardous conditions observed.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

040262 - Deceased Child, Male, 7 Mons	040264 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Substantiated
040262 - Deceased Child, Male, 7 Mons	040264 - Mother, Female, 18 Year(s)	DOA / Fatality	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:

The SS was 7 months old and unable to speak. The Specialist observed and assessed the SS. There were no other surviving children in the household.

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?	☒	☐	☐	☐
Explain: ACS did not assess whether the physical condition of the home was hazardous to the safety of the SS within 24 hours of receipt of the 8/10/17 report. During subsequent visits to the home on 8/11/17, 8/12/17, 8/25/17 and 10/24/17, ACS did not adequately assess the living conditions and the sleeping arrangements as directed in the supervisory notes.				

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 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: N/A				

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: friend							
Additional information, if necessary: The SM accepted PPRS services with JCCA. ACS made EI and DC referrals for SS. It was unclear if the SM utilized the EI and DC as follow up was not documented prior to the closing of the investigation. ACS also offered services to the BF.							

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:
There were no services provided to support the SS in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There were no services provided to the SM, BF or SF to address any immediate needs related to the fatality.

History Prior to the Fatality

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, PS and BF did not have CPS history as parents.

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