Child Fatality Report

Report Identification Number: SY-18-021

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

Issue Date: Oct 04, 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: Onondaga
Gender: Male
Date of Death: 06/01/2018
Initial Date OCFS Notified: 06/04/2018

Presenting Information

On 6/1/18, 3 reports were registered by the SCR regarding the death of the 7-month-old SC. Together, it was alleged on 5/31/18 the adult household members had a family party and all became intoxicated on alcohol, unable to adequately care for the SC, his 5-year-old sibling, and their 1-year-old cousin. The SF took the SC into his bed and they fell asleep together. The SF awoke around 7:30 AM and found the SC between the bed and the wall with his lips blue, and not breathing. The SF called for EMS. The home conditions were poor, and hazardous to the children's health. The third report alleged both parents slept with the SC on the night of his demise, while they were impaired on alcohol and heroin. It was alleged the SM rolled on top of the SC, causing his death. It was further noted their drug use made them unable to care for the SS.

Executive Summary

On 6/1/18, Onondaga County Department of Social Services (OCDSS) responded to an SCR report of a fatality. The 7-month-old SC allegedly died after bed-sharing with the SF; prior, the adults in the home were allegedly too intoxicated to adequately care for the SC and 2 other young children in the home.

The SF was the last person to see the SC alive, and he explained that he, SM, MA, and MGM had a few alcoholic beverages during the evening while the MGF remained sober. The SF laid down in bed with the SC around 10:30 PM on 5/31/18. The SF awoke around 7 AM and found the SC wedged between the mattress and the wall, unresponsive. The SF called 911, and EMS responded along with LE. The Medical Examiner Investigator also responded to the scene.

OCDSS obtained the Medical Examiner's autopsy report, and noted the cause of the SC's death was, "Suffocation due to unsafe sleeping environment." The manner of death was accidental. The preliminary autopsy report detailed that the SC had no known medical history and was found face-down in a pillow between an adult bed and wall. OCDSS documented LE did not file any criminal charges.

In the first 24 hours, OCDSS saw the home, interviewed the parents about the fatality, and observed the 2 surviving children. OCDSS observed the 5-year-old SS on multiple occasions thereafter and assessed her as safe, though she was not formally interviewed. The parents denied they were impaired by drugs the night of the incident, and the SF was the only adult who slept with the child. Despite the SF's account that the MGF was sober during the night and capable of being a caretaker for the 3 children in the home while the other adults consumed alcohol, he was never interviewed and did not corroborate this. The parents were the only family members residing in the home who were interviewed. The MA, who initially resided in the home with her 1yo child, was reported to have moved out of the home prior to 7/10/18. OCDSS used this information to take the MA and her child off the case, and thus no information was gathered to assess ongoing safety or risk to that child.

OCDSS referred the parents and the SS to grief counseling. After gathering information from the parents, the ME, and other first responders, OCDSS concluded the SF did not make an appropriate decision to practice safe sleep with the SC. For this reason, the allegation of IG was substantiated. OCDSS did not capture the link between this parental action to the official cause of death, and therefore inappropriately unsubstantiated the allegation of DOA/Fatality against the SF. All other allegations were unfounded, with justification that there was one sober adult in the home at the time of the incident; however, OCDSS did not adequately corroborate this.

PIP Requirement
OCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS will review the plan and revise as needed to address ongoing concerns.

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:
Sufficient information was gathered to determine all of the allegations, and the decision to indicate the case was appropriate; however, the DOA/Fatality allegation was unsubstantiated despite the evidence gathered to warrant a substantiation of that allegation.

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 decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	OCDSS did not capture the link between the SF's actions to the official cause of death, and therefore inappropriately unsubstantiated the allegation of DOA/Fatality against the SF.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)

Action:	OCDSS will refer to the CPS Program Manual, review 10-OCFS-LCM-15 and 13-OCFS-LCM-01, and if necessary, consult with the Syracuse Regional Office when determining the appropriateness of allegations. OCDSS will take into consideration all information when applying the circumstances to the definition(s).
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP did not reflect the SF's responsibility in causing the circumstances which led to the SC's death, as specified from the final autopsy report.
Legal Reference:	18 NYCRR 432.2(d)
Action:	OCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	There was no 30-Day Safety Assessment completed.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	A safety assessment will be completed and approved by a supervisor within 30 days of a report if such report contains the allegation of DOA/Fatality, in accordance with statutory requirements.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	Safety assessments noted no safety factors with reasoning that the MGF was the sober caretaker in the home; however, MGF was never interviewed nor was the other adult in the home in order to corroborate this. Safety factors were not fully explored.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each safety assessment must be accurately documented in the case record in order to reflect case circumstances with regard to safety.
Issue:	Face-to-Face Interview (Subject/Family)
Summary:	The MGF was a subject of the report and not interviewed. The MA lived in the home during the investigation and was not interviewed; she was determined to be "reported in error" just before the case closed. The 5yo SS was never interviewed.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report. Such interviews or reasons why an interview was not possible should be documented in progress notes.
Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	The MA, an alleged subject, & her child, allegedly maltreated, were removed from the case as "reported in error" 7 days before the case closed. This was inappropriate, given they resided in the home for a substantial period during the investigation.
Legal Reference:	18 NYCRR 428.1 (b)(1)
Action:	OCDSS will review the criteria to determine whether a person may be removed from the case as "reported in error."

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/01/2018 **Time of Death:** 08:01 AM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 07:52 AM
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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 9 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☒ Other: The level of alcohol impairment was not specified.

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	Aunt/Uncle	No Role	Female	28 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	7 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	67 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	64 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Other Child - SC's Cousin; MA's Child	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Year(s)

LDSS Response

In the first 24 hours of receiving the report, OCDSS initiated an investigation and documented the ME, DA, and LE had been notified. OCDSS reviewed CPS history and responded to the home. OCDSS interviewed the SC's parents and discussed the events leading up to the fatality. OCDSS observed both surviving children who resided in the home, as well as the home environment. The home met minimal standards, though it was noted there were several beer cans throughout.

The SF explained he was the last to see the SC alive. He consumed a few beers, along with the SM, MA, and MGM for the MGF's birthday; he claimed the MGF did not drink. The SF took the SC to bed with him around 10:30 PM and put him in his queen-sized bed. The preliminary forensic autopsy summary documented the SC was placed to sleep on the adult bed propped on a U-shaped pillow with the SF also in the bed, and was subsequently found face-down in a pillow between the bed and the wall. The SF reported he awoke around 7 AM and observed the SC between the mattress and the wall, and knew he was deceased. He said he notified the SM and called 911 (though the 911 tapes showed it was MGF who called). The other children were in the home at the time, though their exact whereabouts at the time of the fatality were not specified. The record did not reflect whether the SC had taken any medications, though the ME noted the SC had no known medical history. Information was requested of the pediatrician, but was not received before the case closed.

According to the SM, she remained awake most of the night in another room of the home with the MGM and MA. The record did not reflect whether the parents were questioned about their level of intoxication, and whether their ability to care for the children had been impaired. The SF stated the MGF had not consumed any alcohol that night, though no one corroborated this – the MGF was never interviewed, nor was the MGM or MA. At the initial home visit, the SM reported to the CW that she had been drinking that morning in response to her son's passing. OCDSS administered a drug test to the SM on 6/4/18 and to the SF on 6/8/18. The SM was negative for all substances; the father tested positive for a drug which he admitted to using after the SC died, while the SS was in the care of his sister. The parents were not referred to any drug or alcohol services, as the need was not specified. OCDSS did refer the family to grief counseling, Healthy Families, offered funeral assistance, and assisted with obtaining a plaque in the child's memory.

The parents resided separately with family members following the fatality, and each shared time with the SS. At a home visit on 7/10/18, the SM reported the MA and her child were no longer living there, but they often came and went. Additional attempts to speak to the MA were not made. Just prior to the closing of the investigation, the MA and her child were taken off the case as "Reported in error;" however, this does not appear to be an accurate reflection of the circumstances, as they resided in the home at the time of the report and during the first month of the investigation.

OCDSS obtained the final autopsy report on 8/24/18 and learned the cause of the SC's death was a result of suffocation from an unsafe sleeping environment. Despite this evidence, the allegation of DOA/Fatality was unsubstantiated against the SF, who was the primary caregiver responsible for placing the child in the unsafe environment which led to his death. All allegations were not fully explored, given that all family members were not interviewed. Throughout the investigation, OCDSS documented the SS was safe and there was no need for further services beyond those which they had been referred to in the community.

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

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

Comments: The fatality has not yet been reviewed by the Onondaga County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047582 - Deceased Child, Male, 7 Mons	047585 - Grandparent, Male, 67 Year(s)	Inadequate Guardianship	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047585 - Grandparent, Male, 67 Year(s)	Lack of Supervision	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047585 - Grandparent, Male, 67 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047584 - Father, Male, 34 Year(s)	DOA / Fatality	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047584 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
047582 - Deceased Child, Male, 7 Mons	047583 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047584 - Father, Male, 34 Year(s)	Lack of Supervision	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047583 - Mother, Female, 28 Year(s)	Lack of Supervision	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047585 - Grandparent, Male, 67 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047583 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047585 - Grandparent, Male, 67 Year(s)	DOA / Fatality	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047583 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047584 - Father, Male, 34 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
047582 - Deceased Child, Male, 7 Mons	047583 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047585 - Grandparent, Male, 67 Year(s)	Inadequate Guardianship	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047583 - Mother, Female, 28 Year(s)	Lack of Supervision	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047585 - Grandparent, Male, 67 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047584 - Father, Male, 34 Year(s)	Lack of Supervision	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047583 - Mother, Female, 28 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047583 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated

047587 - Sibling, Female, 5 Year(s)	047584 - Father, Male, 34 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047584 - Father, Male, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047584 - Father, Male, 34 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047585 - Grandparent, Male, 67 Year(s)	Lack of Supervision	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047583 - Mother, Female, 28 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
047587 - Sibling, Female, 5 Year(s)	047585 - Grandparent, Male, 67 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
Caretakers / Babysitters	☐	☒	☐	☐
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 5yo SS was not interviewed, nor were the grandparents, one of whom was a subject. One subject lived in the home but was not interviewed and was recorded as "reported in error." Records were requested from the pediatrician but not received.

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:
By day 7, there were two alleged subjects who were not interviewed - one was the mother of the 1yo child. There was not a sufficient amount of information gathered to make a well-informed decision about the safety of the children. No 30-day Safety Assessment was completed.

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:
The RAP did not reflect the SF's responsibility in causing the circumstances which led to the death of the SC.
Some services were offered. Others may have been beneficial, but were not offered; for example, a substance abuse referral may have been beneficial due to both parents' admissions to using substances as a coping mechanism in response to the fatality and SF's positive drug screen. Without an interview of the MA, there was insufficient information gathered to assess risk to her child, though ultimately both were removed from the 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: No child needed to be placed.				

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: Healthy Families

Additional information, if necessary:
Information on bereavement services was offered to the household members as well as immediate family members whom OCDSS came into contact with. The family was referred to Healthy Families.

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:
OCDSS referred the family to counseling services for the SS, though it was not apparent services were utilized while the case was open.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
OCDSS made service referrals to the family. OCDSS helped the family obtain a plaque in the child's memory. Referrals were made to the SC's parents for grief counseling.

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

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS 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