Child Fatality Report

Report Identification Number: NY-20-102

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

Issue Date: Apr 14, 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: 9 month(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 02/14/2020
Initial Date OCFS Notified: 11/06/2020

Presenting Information

An SCR report was received on 2/14/20 with concerns of the subject child's death. The report was investigated and OCFS issued a fatality report. Another SCR report was received on 11/6/20 with new concerns that on 2/14/20, while in the care of the mother, father, and other family members, the nine-month-old child died due to fentanyl poisoning. It was unknown who gave the child fentanyl. At 3:00PM that day, the mother put the child and his twin down for a nap in the same crib. The crib also contained a body pillow and other objects. At 4:30PM, the father checked on the children and found the subject child face down and unresponsive. At the time of the death, the children and adult family members were ill, and the child had a low grade fever. The child was given over the counter medications. The child's original cause of death was noted as viral pneumonia; however, on 11/6/20, the final autopsy was released, which noted the child's death was due to acute fentanyl intoxication. The manner of the child's death was changed to homicide.

Executive Summary

This fatality report concerns the death of a nine-month-old male subject child that occurred on 2/14/20. A report was made to the SCR on 11/6/20 with allegations of Inadequate Guardianship, Poisonous/Noxious Substances, and DOA Fatality against the child's mother, father, aunt, uncle and grandfather. A previous Child Fatality Report regarding this child was issued by the New York State Office of Children and Family Services on 7/21/20. The Administration for Children's Services (ACS) had completed a fatality investigation at the time the child died; however, when that case was closed, a cause and manner of death had not yet been determined. The final autopsy was released on 11/6/20, and it indicated the child died due to acute fentanyl poisoning. The manner of death was determined to be homicide. Given this new information, the fatality was re-reported to the SCR and a new investigation was initiated.

At the time of the child's death, he resided with his mother, father, 4-year-old sister and 9-month-old twin brother. Also, in the home was a maternal aunt, her one-year-old child, a maternal uncle and a maternal grandfather. The investigation revealed on the afternoon of 2/14/20, the father was at home with the child and siblings while the mother was at a nearby laundromat. The father fed the child and his twin at approximately 2:00PM, and then laid the twins in the same crib for a nap. The crib contained a sheet and a body pillow, and both children were placed on their backs to sleep. The father and the sibling fell asleep in the same room as the twins, and the mother arrived home at some point while all were sleeping. At 4:00PM, the twin sibling awoke, and the father got out of bed to check on her. At that time, the father found the subject child face down in the crib and unresponsive. The father called out for the mother, who began cardiopulmonary resuscitation while the father contacted emergency services. The ambulance arrived shortly thereafter and transported the child to the local hospital, where he was pronounced deceased at 5:27AM.

From the time the investigation began to the time of its closure, ACS interviewed family members and collateral sources. All adults in the household denied using or possessing illicit substances and had no knowledge as to how the subject child could have ingested fentanyl. Although the safety of the siblings and cousin was assessed within 24 hours, ACS did not complete the assessment in CONNECTIONS timely. ACS sought family court intervention, the SS was removed and placed in foster care, and a mandatory services case was opened. The criminal investigation and family court proceedings remained ongoing at the time of this writing.

PIP Requirement

ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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:
ACS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving siblings and cousin.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	Although the safety of the SS and cousin was assessed within 24 hours and documented in progress notes, the initial safety assessment was not completed and approved in CONNECTIONS until 11/9/20, two days late.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)

Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed, and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/14/2020 **Time of Death:** 05:27 PM

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

County where fatality incident occurred: New York
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? 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? 1 Hours
At time of incident supervisor was: Not impaired.

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	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Male	54 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	9 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	52 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	65 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Other Adult - Cousin	No Role	Male	37 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	9 Month(s)

Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)

LDSS Response

ACS received the SCR report on 11/6/20 concerning the previously reported fatality that occurred on 2/14/20. The death was initially reported to the SCR on that same date and was investigated by ACS with the coordination of their multidisciplinary team. A Child Fatality Report regarding that investigation was issued by the New York State Office of Children and Family Services on 7/21/20.

On 11/7/20, ACS and LE re-interviewed all adult family members with the new information received from the ME regarding SC's toxicology results. The record reflected the family appeared "shocked" by the findings and adamantly denied knowing how SC could have ingested fentanyl. SF stated they were told months ago that SC died from viral pneumonia. SM explained there were family members in the home several months prior to SC's birth who were on hospice care; however, neither of those family members were prescribed that medication. Family members also denied anyone in the home used illicit substances or was prescribed fentanyl, and all adults agreed to a drug screening. Due to the determination that SC's death was a homicide, ACS removed the SS from the home and placed them into kinship foster care; the 1yo cousin was with a family member in a neighboring county and ACS requested that county assess her safety. The verbal SS was interviewed and expressed no safety concerns.

On 11/10/20, ACS spoke with the ME who advised fentanyl, or a drug that mimics fentanyl, would not be found in any over the counter medications. The ME explained the preliminary cause of death was noted as pneumonia due to SC testing positive for the virus, and a lung infection was evident. The ME further stated the SC was well nourished and free from suspicious injury. The ME stated the toxicology results were received in September 2020; however, the autopsy was not finalized until 11/6/20 due to the ME gathering information surrounding any medications given to SC when he was at the hospital on the date of his death.

During the new fatality investigation, ACS gathered no new information surrounding who was responsible for the death of SC. Drug testing resulted in only the parents testing positive for marijuana, and services were offered to address this. At the time of this writing, there were no criminal charges brought against any of the adults in the household; however, the LE investigation was ongoing. ACS noted that although none of the adults in the home reported they knew how or when SC ingested fentanyl, they were all responsible for SC's safety and SC died while in their care. Therefore, ACS substantiated all of the allegations in the report and closed the investigation. The SS and cousin remained in the care of relative resources, and a mandatory services case was opened and ongoing at the time of this writing.

Official Manner and Cause of Death

Official Manner: Homicide
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: This fatality investigation was conducted by the ACS multidisciplinary team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056793 - Deceased Child, Male, 9 Month(s)	056794 - Aunt/Uncle, Female, 27 Year(s)	DOA / Fatality	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056800 - Aunt/Uncle, Male, 54 Year(s)	Poisoning / Noxious Substances	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056800 - Aunt/Uncle, Male, 54 Year(s)	Inadequate Guardianship	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056800 - Aunt/Uncle, Male, 54 Year(s)	DOA / Fatality	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056799 - Mother, Female, 22 Year(s)	Poisoning / Noxious Substances	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056799 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056799 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056798 - Grandparent, Male, 52 Year(s)	Poisoning / Noxious Substances	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056798 - Grandparent, Male, 52 Year(s)	DOA / Fatality	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056795 - Father, Male, 24 Year(s)	Poisoning / Noxious Substances	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056795 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056795 - Father, Male, 24 Year(s)	DOA / Fatality	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056794 - Aunt/Uncle, Female, 27 Year(s)	Poisoning / Noxious Substances	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056794 - Aunt/Uncle, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
056793 - Deceased Child, Male, 9 Month(s)	056798 - Grandparent, Male, 52 Year(s)	Inadequate Guardianship	Substantiated
056796 - Sibling, Female, 9 Month(s)	056799 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
056802 - Sibling, Female, 4 Year(s)	056799 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐

Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

ACS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered timely.

Fatality Safety Assessment Activities

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

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐

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

Explain:
Due to the ME's findings that the manner of SC's death was homicide, ACS removed the CHN from the home and placed them into kinship foster care. A mandatory services case was opened in response.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The siblings and cousin were removed due to the new information that the child's death was a homicide. The children were placed with relative resources.

Legal Activity Related to the Fatality

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

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/09/2020	There was not a fact finding	Custody Transferred to Relative or Non-Relative Foster Care
Respondent:	056799 Mother Female 22 Year(s)	
Comments:	The surviving siblings were removed from the care of their mother and father, and placed in kinship foster care. An abuse petition was filed and the parents were to have supervised visitation only. The family court proceedings remained ongoing at the time of this writing.	

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
11/09/2020	There was not a fact finding	Custody Transferred to Relative or Non-Relative Foster Care
Respondent:	056795 Father Male 24 Year(s)	
Comments:	The surviving siblings were removed from the care of their mother and father, and placed in kinship foster care. An abuse petition was filed and the parents were to have supervised visitation only. The family court proceedings remained ongoing at the time of this writing.	

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
11/09/2020	There was not a fact finding	CustodyGuardianship assigned to relative or non-relative (Article 6 non-foster care)
Respondent:	056794 Aunt/Uncle Female 27 Year(s)	
Comments:	The cousin was removed from the care of the maternal aunt and placed with her paternal grandmother. An abuse petition was filed and the aunt was to have supervised visitation only. The family court proceedings remained ongoing at the time of this writing.	

Have any Orders of Protection been issued? Yes

From: 11/10/2020	**To:** Unknown

Explain:
The parents and maternal aunt were to have supervised visits with their children until further information regarding the subject child's death could be obtained.

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: Mandated Preventive Services

Additional information, if necessary:
ACS provided the family with bereavement counseling referrals and information on assistance with funeral costs. The parents tested positive for marijuana during the investigation and agreed to substance abuse evaluations. A mandatory preventive services case was opened after the children were removed from the household.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
ACS provided referrals for grief and bereavement counseling to the parents for the SS. A mandatory services case was opened in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS provided the parents and other family members referrals for grief counseling and bereavement services. A mandatory services case was opened in response to the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? Yes

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)
02/14/2020	Deceased Child, Male, 9 Months	Father, Male, 24 Years	DOA / Fatality	Unsubstantiated	No
	Deceased Child, Male, 9 Months	Father, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 9 Months	Mother, Female, 22 Years	DOA / Fatality	Unsubstantiated	
	Deceased Child, Male, 9 Months	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that on 2/14/20, the 9-month-old subject child died while in the care of the mother and father. The report alleged at 3:00PM that day, the mother put the child and his twin sister to sleep in their shared crib, and around 4:30PM the mother noticed something was wrong with the child. The child was unresponsive when the fire department arrived. The child was transported to the hospital and pronounced dead at 5:27PM.

Report Determination: Unfounded | **Date of Determination:** 04/13/2020

Basis for Determination:
ACS completed interviews with family members and collateral sources including medical providers, school staff, LE and the ME. Although the final autopsy report was not yet available at the conclusion of this investigation, ACS spoke with the ME who informed ACS that SC appeared to be a healthy infant, with no signs of trauma or injury to his body. ACS found no evidence SC's death was the result of abuse or maltreatment by the parents, and therefore unsubstantiated the allegations.

OCFS Review Results:
This investigation met all statutory requirements.

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