NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-075 **Prepared by: New York City Regional Office**

Issue Date: 12/30/2016

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 22 day(s)
Jurisdiction: New York
Gender: Male
Date of Death: 07/20/2016
Initial Date OCFS Notified: 07/20/2016

Presenting Information

On 7/20/16, the SCR report alleged, the SF fell asleep on the sofa with the SC on his chest. The SF woke up and the SC was between the SF's side and the back of the sofa; not breathing. The SC had no visible injuries. the role of the BM and the 2-year-old sibling were unknown.

On the same date, a SCR report alleged the BM breastfed the SC, then handed him to the SF who burped him. The SF laid on the sofa with SC on top of him and fell asleep, while the BM went back to bed. When the SF woke up, the SC was between the SF's body and the back of the sofa. The SC was found blue and unresponsive. The SF brought the SC into the bedroom and woke up the BM. The BM performed CPR while the SF called 911. The SC was transported to the hospital where he later died. The SC had no visible injuries to his body. At the time of the incident, the SC was in the care of the SF; therefore, he was named as the alleged subject.

Executive Summary

The 22-day-old SC died on 7/20/16. The allegations of the 7/20/16 SCR report were DOA/Fatality and IG of the SC by the SF. As of 12/20/16, NYCRO has not received the autopsy report; however, according to the the ME's preliminary findings, the cause of death was positional asphyxia and the manner of death was an accident. The SC was found wedged in between the SF and the sofa where the SF had been sleeping with the SC.

On 7/19/16 at approximately 8:00 PM, the parents played with the children before the BM fed the surviving sibling (SS). The SF and BM ate dinner and the SS went to sleep in the bedroom at approximately 8:30 PM. The SC was passed back and forth between SF and BM as the BM worked on the computer. About 10:00 PM, the SF shared a bottle of wine with friends who visited the home. The BM declined to consume wine and the SF drank another glass of wine and a bottle of beer as he watched television. The BM breast fed and burped the SC.

At approximately 11:00 PM, the BM pumped breast milk to allow the SF to bottle feed the SC. The BM left the SC in the care of the SF and went into the bedroom to sleep. The SF remained in the living room on the sofa with SC. Later, the SF bottled fed the SC. The SC drank about 2oz of breast milk. The SF dosed off with the SC on his chest around 12:30 AM. It was approximately 2:30 AM, when the SF observed the SC's body wedged between the sofa and the right side of SF's body. The SF observed that the SC's face was pressed into the SF's body and the SC was unresponsive.

The SF alerted the BM. The BM placed the SC on the floor and began CPR. The SF dialed 911 and the operator provided the parents CPR instructions. LE arrived first to the scene. The EMS arrived as LE and the parents were leaving the building. The SC and BM were transported to the Hospital and the SF stayed at the family's apartment with the SS until a family resource arrived to care for the SS. The SF arrived at the hospital about 20 minutes after EMS left the apartment building. The SC's arrival time at the ER at Lenox Hill Hospital and the reason for his transfer to Cornell Hospital were unclear.

The SC was transferred to Cornell Hospital at 6:40 AM and he received emergency assistance. The Dr. discussed the SC's worsening condition with the parents. At 1:24 PM on 7/20/16 the SC died.

On 7/25/16, ACS offered the parents bereavement and early intervention (EI) services and the Family Services Stage (FSS) was opened. Later, the parents declined all offered service referrals by ACS and decided to seek services privately. On 7/27/16, the parents completed intake with a private service provider. The FSS stage remained open until 12/20/16 .

The Specialist continued to monitor and assess the SS in the home. On 12/6/16, the SS was successfully observed; he appeared healthy and free of marks or bruises. The home had adequate sleeping arrangements and provisions for the SS. There were no safety concerns.

On 12/10/16, ACS substantiated the allegation of DOA/Fatality and IG of the SC by the SF on the bases that the SF failed to exercise a minimum degree of care in providing proper care of the SC by placing the SC in imminent danger. The SF consumed alcohol with his prescription medication and fell asleep with the SC on the sofa, which resulted in the SC being wedged between the SF and the sofa causing the SC's death. The parents were aware of the dangers of consuming alcohol with the prescribed medication; therefore, ACS added and substantiated the allegation of IG of the SC by the BM. The BM observed the SF consume alcohol and she did not ensure the SC was placed in the bassinet and this resulted in the SC's death.

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

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 Specialist gathered sufficient information to make determination for all allegations including those on the intake report in the course of the investigation. The determination made by ACS to indicate the report was appropriate.

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:	The 24-Hour Safety Assessment was not approved within the specified timeframe and there was no safety plan completed for the selected safety decision that required a Safety Plan to be completed for the 24-Hour Safety Assessment.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a corrective action plan 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:	The 30-Day Fatality Report was not approved within the specified timeframe.
Legal Reference:	CPS Program Manual, VIII, B.2, page 4
Action:	ACS must submit a corrective action plan 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
Summary:	Although noted in the 24-Hour Fatality Report, the initial observation and assessment of the surviving sibling and the home environment was not documented in the progress notes. The first documentation of a visit to the case address was on 8/8/16.
Legal Reference:	18 NYCRR 428.5(c)
Action:	ACS must submit a corrective action plan 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:	There were untimely entered investigative progress notes observed and entered on 8/23/16 for event date 7/21/16 as well as a significant number of untimely entered FSS progress notes.
Legal Reference:	18 NYCRR 428.5(a) and (c)
Action:	ACS must submit a corrective action plan 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:	Diligence of Efforts
Summary:	Documentation of efforts to obtain the 911 and EMS route log information was not observed in the

	progress notes.
Legal Reference:	NYCRR 430.12D
Action:	ACS must submit a corrective action plan 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:	There was no safety plan completed for the selected safety decision that required a Safety Plan to be completed for the 7-Day Safety Assessment.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a corrective action plan 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:	Predetermination/Assessment of Current Safety and Risk
Summary:	The Risk Assessment contained inaccurate response selections and comments to risk assessment questions which yielded an inaccurate Preliminary Risk Rating.
Legal Reference:	18 NYCRR 432.1(aa)
Action:	ACS must submit a corrective action plan 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:	Failure to provide notice of report
Summary:	Documentation that the SF and BM were provided the notices of existence was not observed in the investigation.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan 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:	Failure to Provide Notice of Indication
Summary:	Documentation that the SF and BM were provided the notices of indication was not observed in the investigation.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must submit a corrective action plan 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: 07/20/2016 **Time of Death:** 01:24 AM

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 to 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
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:

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	22 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

According to LE, the parents' behaviors were appropriate upon the Dr.'s announcement of the SC's death. The parents' had no DV or criminal history. No arrests were made.

The parents said the SC had no medical concerns prior to his arrival at the hospital. The hospital provided the parents with bereavement counseling and funeral home resources.

According to the attending Dr., the SC arrived to the hospital in cardiac arrest. The SC was administered supportive medication. However, the SC's condition worsened. The Dr. discussed the gravity of the SC's condition with parents. The Dr. said there was no evidence of abnormalities with the SC and that the SF did not appear to be under the influence at the time. The parents' statements of the incident were consistent with the SC's injuries.

The Specialist interviewed the parents separately at the hospital. The BM said at approximately 10:00 PM, friends visited the home and the parents opened a bottle of wine. Everyone except the BM had one glass of wine. The BM admitted the parents occasionally co-slept in the bed with the SC for a few hours despite having received safe sleep education. The SF said he took his prescribed medication after 8:00 PM dinner and then consumed wine and beer with friends. The SF denied he had been intoxicated while caring for the children. The SF explained he recently had surgery for a medical condition and was informed by the Dr. of the side effects of the drinking alcohol with his prescribed medication. The BM confirmed she was aware of the contraindication of the SF taking the medication while he consumed alcohol. There were no inconsistencies noted in either parent's statement.

The ME stated there was no trauma of the SC observed during the autopsy. The autopsy results were accurate with the parents' statements. There was no sign of abuse or criminal activity.

On 8/22/16, the family therapist confirmed the parents completed intake on 7/27/16 for weekly sessions to include bereavement, individual and couple's counseling.

On 9/2/16, the nanny stated she observed unopened bottles of wine in the parents' home but had not witnessed the parents drinking the wine in her presence; she did not observe the parents under the influence of alcohol.

The family resource confirmed caring for the SS the night of the incident. The resource had no concerns regarding the care the parents provided to the SC and SS.

On 9/6/16, the parents, PA, and their attorney attended the Initial Child Safety Conference (ICSC) at the LDSS office. The BM stated she drank a glass of wine while pregnant and continued to have a glass of wine as a breastfeeding parent. The 8/15/16 results of the SF's random drug screening was negative for all substances. The substance abuse consultant noted that neither parent required substance abuse services. ACS discussed bereavement services for the family and EI for the SS. The parents and their attorney declined all offered service referrals by ACS and decided to continue services privately.

According to the children's medical Dr., the SC was healthy and the SS's immunizations were up to date. The Dr. had not witnessed the parents under the influence and had no concerns regarding the care they provided the children.

On 9/19/16, the SF's Dr. confirmed the SF's treatment participation. The Dr. said the SF was prescribed medication for a behavioral and medical condition. The SF informed the Dr. of his alcohol consumption. The Dr. stated the SF was counseled on the side effects of alcohol consumption with the SF's prescribed medications.

On 12/10/16, ACS indicated the report. The family refused services.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Hospital physician

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
030061 - Deceased Child, Male, 22 Days	030064 - Father, Male, 36 Year(s)	Inadequate Guardianship	Substantiated
030061 - Deceased Child, Male, 22 Days	030064 - Father, Male, 36 Year(s)	DOA / Fatality	Substantiated
030061 - Deceased Child, Male, 22 Days	033621 - Mother, Female, 35 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:
progress notes were not entered contemporaneously. Notes for event date 7/21/16 were entered 8/23/16.

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?	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

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	Needed but not Offered	Needed but Unavaliable	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:
The SF and BM were offered services. The parents declined referrals and decided to seeks services privately.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/20/2016	13204 - Deceased Child, Male, 22 Days	13206 - Mother, Female, 35 Years	Inadequate Guardianship	Indicated	No
	13204 - Deceased Child, Male, 22 Days	13207 - Father, Male, 36 Years	Inadequate Guardianship	Indicated	

Report Summary:
The 7/20/16 SCR report alleged, the SF fell asleep on the sofa with the SC on his chest. When the SF woke up the SC was between the SF's side and the back of the sofa and not breathing. SC had no visible injuries. The role of the BM and

the 2-year-old sibling were unknown.	
Determination: Indicated	**Date of Determination:** 12/20/2016
Basis for Determination: ACS substantiated the allegation of IG of the SC by the subject parents (SP) on the bases that the SP failed to exercise the minimum degree of care in providing proper supervision and guardianship of the SC, placing the SC in imminent danger. The SF exercised poor judgment in mixing prescribed medication and consuming alcohol while he cared for the SC. The SM acknowledged she was aware of the side affects of the SF mixing medication and consuming alcohol; however, she did not take appropriate action to create an alternative sleeping arrangement for the SC.	
OCFS Review Results: Hours prior to the SCR report of the fatality, ACS was in the process of investigating a registered SCR report concerning allegations of IG of the SC by the SF. Therefore, ACS conducted the investigations of the two reports simultaneously.	
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No	

CPS - Investigative History More Than Three Years Prior to the Fatality

The family has no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family has no CPS history outside of NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Casework Contacts

	Yes	No	N/A	Unable to Determine

Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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