Child Fatality Report

Report Identification Number: NY-18-040

Prepared by: New York City Regional Office

Issue Date: Oct 16, 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: 6 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 04/20/2018
Initial Date OCFS Notified: 04/20/2018

Presenting Information

The SCR report alleged on 4/17/18, the six-month-old infant was taken by his mother to his immunization appointment. She then took the SC home and left him in the care of the SF who changed him and put him in his bassinet. The SF checked the SC later and found a green substance excreting the SC's nostril. The SF initiated CPR and called 911. The SC was admitted to the hospital on 4/17/18. Since admission, the SC was found to have a subdural hematoma, an occipital fracture, and bilateral retinal hemorrhaging. Tests done on 4/19/18 and 4/20/18 reflected the SC had no brain activity. The SC was declared dead on 4/20/18 at 1:20 PM. The cause of death was brain death by injuries suffered by non accidental trauma. The report alleged all household members as subjects.

Executive Summary

This 6-month-old male SC died on 4/20/18 after being hospitalized on 4/17/18. The autopsy report has not yet been received from the ME.

The allegations of the SCR report were DOA/Fatality, Fractures, Internal Injuries, and Inadequate Guardianship of the 6-month-old SC by the SF. However, as ACS' investigation progressed, the allegation of DOA/Fatality was added on behalf of the SC against all of the adult household members.

According to ACS' case documentation, the SC was injured on 4/17/18, and was hospitalized at Woodhull Hospital (WH). The SC was then transferred to New York University Hospital (NYUH) for a higher level of care and it was at NYU that it was revealed the child had a subdural hematoma, an occipital fracture and bilateral retinal hemorrhaging. During the hospitalization, additional tests were conducted and it was established the SC had no brain activity. The SC was pronounced dead at 1:20 pm on 4/20/18.

ACS' Brooklyn Field Office staff conducted the investigation and determined there were no surviving siblings or other children in the home. The SM reported she was not at home at the time of the incident; she received a call from the SF alerting her to the situation. The SM reported the SC had no prior medical issues; however, he received a vaccination earlier that day. The SM initially denied DV but later disclosed incidents of physical and verbal abuse by the SF; she also disclosed episodic alcohol use. The SM stated the SF had never abused the SC; however, the MGM disclosed an incident of possible abuse of the SC by the SF. The MGM did not report her suspicions to the authorities. The SF reportedly resided at a separate location.

The SF reported that on 4/17/18, he changed the SC and the child fell asleep shortly after. He then placed the SC on his back in the bassinet, and about 5 minutes later noticed mucous coming from the SC's nostrils. The SF said he initiated CPR and called 911; an ambulance responded and transported the SC and SF to the ER.

On 4/23/18, ACS contacted the ME and was informed the case was referred to a neuro-pathologist who would determine whether the SC sustained a blunt impact injury or an injury caused by shaking. LE suspected homicide; however, the SF was released after their initial interview. The ME reported the SC had old bite marks on his left buttocks.

On 4/30/18, the Specialist received information from the SC's Dr who stated the SC was initially seen at the clinic on 2/16/18 and two other times by two other physicians. The Dr reported there was no suspicion of abuse or neglect. The SC appeared well during the examination on the morning of the incident. The SC was up to date with immunizations and

there was never a discovery of marks on the SC who was in good health.

The Specialist interviewed the 24-year-old MU who was in the home at the time the SC was taken to the hospital; he said he did not intervene. The Specialist attempted to interview household members and gathered information from each person; the family members were reluctant to be interviewed. ACS learned of a strained family relationship because the family objected to the relationship between the SM and SF. The family members denied physical abuse of the SC, mental health, DV, drugs, or excessive alcohol use by those living in the home.

On 6/20/18, ACS unsubstantiated the allegations of DOA/Fatality, Internal Injuries, Fractures, and Inadequate Guardianship of the SC by three MUs as they were not persons legally responsible for the SC. The allegations against the MGM were also unsubstantiated as she was not in the home at the time of the incident. ACS substantiated all allegations pertaining to the SC by the parents. ACS made the decision to substantiate the allegations against the mother on the basis she left the SC in the care of the SF knowing that he was not an appropriate caregiver and this led to the SC's demise.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:

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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:

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Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination

Summary:	ACS inappropriately substantiated DOA/Fatality allegation against the SM because she left the SC in the care of the SF knowing they had engaged in DV in the past. ACS did not establish the SF harmed the SC prior to the fatality.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS did not complete a thorough investigation of this report. While contacts were made and some information obtained, there was no follow-up to explore and information obtained from these contacts.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/20/2018 **Time of Death:** 01:42 PM

Date of fatal incident, if different than date of death: 04/17/2018
Time of fatal incident, if different than time of death: 05:20 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 05:50 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Unknown if they were 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	Male	24 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	6 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	59 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	24 Year(s)

LDSS Response

The SCR registered five reports regarding the injury of the SC by the parents and the household members. The initial report was registered on 4/17/18. On 4/18/18, two subsequent reports were registered and consolidated. On 4/20/18, the SCR registered two additional reports with allegations of DOA/Fatality, FX, II and IG of the SC by the parents and household members. All of the reports shared a common narrative that alleged the SC was found unresponsive in his bassinet. After emergency service was summoned the SC was hospitalized at WH and later transferred to NYUH for a higher level of care. The Dr. reported the SC had a subdural hematoma, an occipital fracture, bilateral retinal hemorrhaging, and no brain activity; he was pronounced dead on 4/20/18 at 1:20 pm.

ACS initiated the 4/17/18 investigation and learned the SC was given a vaccine earlier that day. The SC was said to have been in good health when the family arrived home at 3:30 pm. The SF left the SC home with the SM and returned at 5:10 pm. At 5:20 pm, the SM left the SC home with the SF to go to school; the SC was crying. The SF changed the SC, and when the SC fell asleep he was placed in the bassinet. The SF later observed excretion from the SC's nose and attempted CPR. EMS received the 911 call at 5:52 pm. The SF and the MGM rode in the ambulance to the hospital.

According to LE, on 4/17/18, the SF was arrested and released; however, the criminal investigation is pending the final autopsy. ACS learned the MGM and the 27-year-old MU arrived at the home to find the SF holding the SC; the MGM instructed the SF to call 911. The MU attempted CPR until the ambulance arrived. According to the case documentation, the MGM said in the past she had witnessed the SF choking the SM. This information was not reported to LE or other authorities. Three MUs resided in the home and all declined to be interviewed; they stated they had no child care responsibility for the SC.

As part of the routine investigation, ACS contacted the Brookdale Hospital clinic and learned the SC had been seen three times since 2/16/18, each time by a different Dr. The documentation reflected there was no sign of abuse, or concerns regarding the parents, and the SC was up to date with immunizations.

ACS staff interviewed the SM at the hospital and she stated she received a call from the SF alerting her to the situation. The SM denied that the SF abused her or the SC; however, on 5/1/18, the ME reported the SC was observed with old bite marks on his buttocks.

On 5/1/18, the ACS Specialist re-interviewed the SM and MGM. The MGM recalled an incident where she and the SM observed blood on the SC mouth and the SF had no plausible explanation; the SF had been alone with the SC. The Specialist did not explore with the parents the incidents that were disclosed or the old bite marks.

On 6/20/18, ACS unsubstantiated all allegations pertaining to the three MU citing they were not persons legally responsible for the SC. ACS unsubstantiated all allegations of the SC by the MGM because she was not at home the time

the incident occurred. ACS substantiated all allegations relating to SC by the SM stating the SM was aware of DV yet she chose to leave the SC in the care of the SF and it led to the SC's demise. The allegations of the SC by the SF were substantiated.

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)?No
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 NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047701 - Deceased Child, Male, 6 Mons	047705 - Aunt/Uncle, Male, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047705 - Aunt/Uncle, Male, 24 Year(s)	Internal Injuries	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047705 - Aunt/Uncle, Male, 24 Year(s)	Fractures	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047707 - Aunt/Uncle, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047705 - Aunt/Uncle, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047702 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
047701 - Deceased Child, Male, 6 Mons	047702 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
047701 - Deceased Child, Male, 6 Mons	047707 - Aunt/Uncle, Male, 26 Year(s)	Internal Injuries	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047706 - Aunt/Uncle, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047707 - Aunt/Uncle, Male, 26 Year(s)	Fractures	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047704 - Grandparent, Female, 59 Year(s)	Fractures	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047704 - Grandparent, Female, 59 Year(s)	Inadequate Guardianship	Unsubstantiated

047701 - Deceased Child, Male, 6 Mons	047704 - Grandparent, Female, 59 Year(s)	DOA / Fatality	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047702 - Mother, Female, 22 Year(s)	Fractures	Substantiated
047701 - Deceased Child, Male, 6 Mons	047702 - Mother, Female, 22 Year(s)	Internal Injuries	Substantiated
047701 - Deceased Child, Male, 6 Mons	047706 - Aunt/Uncle, Male, 27 Year(s)	Internal Injuries	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047707 - Aunt/Uncle, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047706 - Aunt/Uncle, Male, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047704 - Grandparent, Female, 59 Year(s)	Internal Injuries	Unsubstantiated
047701 - Deceased Child, Male, 6 Mons	047706 - Aunt/Uncle, Male, 27 Year(s)	Fractures	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☒	☐	☐	☐	☐	☐	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: .							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no other children in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The MGM accepted bereavement counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
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? N/A
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)	Allegation Outcome	Compliance Issue(s)
04/17/2018	Deceased Child, Male, 6 Months	Mother, Female, 22 Years	Internal Injuries	Substantiated	No
	Deceased Child, Male, 6 Months	Father, Male, 24 Years	Internal Injuries	Substantiated	
	Deceased Child, Male, 6 Months	Mother, Female, 22 Years	Lacerations / Bruises / Welts	Substantiated	
	Deceased Child, Male, 6 Months	Father, Male, 24 Years	Choking / Twisting / Shaking	Substantiated	
	Deceased Child, Male, 6 Months	Aunt/Uncle, Male, 26 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 6 Months	Aunt/Uncle, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 6 Months	Aunt/Uncle, Male, 27 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 6 Months	Grandparent, Female, 59 Years	Inadequate Guardianship	Substantiated	

Deceased Child, Male, 6 Months	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 6 Months	Father, Male, 24 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 6 Months	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
The six-month-old SC lives with his SM who drinks alcohol until she is intoxicated while caring for the SC. The SM is unable to care for the SC when intoxicated. The SM is physically abusive towards the SC. The SM hits the SC and has left bruises; he cries a lot while in the SM's care.

The allegations of the report were C/ T/ S, II, IG, LBW, PD/ AM of the SC by the parents and household members.

Report Determination: Indicated | **Date of Determination:** 06/14/2018

Basis for Determination:
ACS substantiated the allegations of C/T/S, II, IG, LBW, PD/ AM of the SC by the parents and household members. ACS stated "there is no clear determination as to who caused the serious injury leading to the SC's demise. In addition, ACS unsubstantiated the allegation of PD/AM by the SM "because there is not enough credible evidence because the SM did not take a drug test."

OCFS Review Results:
ACS inappropriately substantiated the three uncles who were not persons legally responsible for the SC. ACS did not apply the legal standards to determine the PD/ AM allegation by the SM.

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 known CPS 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