Child Fatality Report

Report Identification Number: RO-17-015

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

Issue Date: Oct 26, 2017

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		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Chemung
Gender: Male
Date of Death: 04/27/2017
Initial Date OCFS Notified: 05/02/2017

Presenting Information

The SC suffered from Pantothenate Kinase-Associated Neurodegeneration (PKAN) and required 24-hour constant supervision due to having a tracheostomy and GI feeding tube. On 4/27/2017, One of the SC's care aides left the SC unsupervised and as a result the SC pulled on his tracheostomy tube and suffocated. She was one of the three care aides who provided constant care to the SC in the home. The care aide sent a text to the SM to tell her she was leaving at 6 AM. The SM did not come down to be with SC. The care aide then called the SM's cell phone and left a voice message. Subsequently, the care aide left the home without ensuring that someone was supervising the SC. The SM and SF woke up at 7:30 AM and found the SC had pulled out his tube and the SM called 911. The SC was transported to a medical facility and passed away at 6:40 PM. The role of the SM, SF, SSs and the cousin were unknown.

Executive Summary

On 5/3/2017, Chemung County Department of Social Services (CCDSS) received a report alleging DOA/fatality, LS and IG against the care aide for the SC. The SC was a medically fragile child and was required to have 24-hour medical care and supervision. There were three care aides who coordinated their schedules with the SM to ensure 24-hour supervision and monitoring. On the morning of 4/27/2017, the care aide was scheduled to leave at 6 AM. The care aide sent one text and made one call to SM’s cell phone telling her she was leaving. The SM reported she never heard the call or saw the text. When the SSs age 10, age 13, and the cousin age 6, woke up for school, they woke up the SM and the SF. The SM and the SF went downstairs and found the SC had pulled out his tracheotomy tube and the alarms for the machines were sounding. The SM called 911 at 7:48 AM and the SC was transported to the hospital. The SC passed away later that day at 6:40 PM.

In the first 24 hours of the investigation, CCDSS assessed the safety of the SSs and a cousin to the SC who also resided in the home at the time of the reported fatality. There were no immediate safety concerns for the SSs and the cousin. CCDSS initiated a joint investigation with LE. CCDSS offered mental health and trauma services to the family.

During the investigation CCDSS interviewed the source and all first responders. The SM, SF, SSs and the cousin were interviewed and observed. All appropriate collateral contacts were made including but not limited to, pediatricians, home health care providers, treatment professionals, schools and family members. A SCR history check was completed and reviewed. A criminal history check was completed. Both the SF and SM had no known history of drug or alcohol misuse. Based on the investigation, interviews and viewing the video tape from the morning of the incident; CCDSS appropriately added the allegation of DOA/Fatality, LS and IG against the SM and the SF for the SC.

The SM declined an autopsy and the attending physician did not refer the SC to ME’s office. The immediate cause of death listed on the death certificate was complications of Pantothenate Kinase-Associated Neurodegeneration.

CCDSS appropriately IND the report and Sub the allegations of DOA/fatality, LS and IG against the SM and the SF for the SC. There was some credible evidence to support the allegations that both the SM and the SF had advanced notice that the care aide had to leave by 6 AM that morning. In viewing the video recording of that morning that the SM and the SF failed to come downstairs at 6 AM and left the SC unsupervised against medical advice. The SC stopped moving as viewed in the video after pulling out his tube at 6:50 AM. All parties in the home stated the machines attached to the SC would set off loud alarms when this happened but the SM and SF denied hearing the alarms until they came down stairs. The SF and SM came downstairs at 7:38 as observed and 911 was called at 7:48. The allegations of DOA/Fatality, LS and

IG against the care aide were Unsub as she had sent a text and called the SM before leaving. The case was closed and the family was referred to community based services.

The OCFS review resulted in a casework practice citation. The 7 day safety assessment was not completed. LDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) the LDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, LDSS will review the plan(s) and revise as needed to further 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:
CCDSS interviewed all family members, home care providers and reviewed all medical records. CCDSS also reviewed the video of the events leading up to the SC's passing. The SSs were deemed safe.

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:
CCDSS gathered a substantial amount of information from collateral contacts by way of face-to-face interviews, telephone contacts, and copies of records. The information gathered supported the closing of their investigation.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment

Summary:	CCDSS did not complete a 7 day safety assessment.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	CCDSS will complete the 7 day assessment in CONNECTIONS within 7 days of the receipt of a report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/27/2017 **Time of Death:** 06:40 PM

Time of fatal incident, if different than time of death: 06:50 AM

County where fatality incident occurred: Chemung
Was 911 or local emergency number called? Yes
Time of Call: 07:48 AM
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: In bed pulled out his trach

Did child have supervision at time of incident leading to death? No - but needed
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	Deceased Child	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Other Child - cousin	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Stepfather	Alleged Perpetrator	Male	35 Year(s)
Other Household 1	Other - Aide for the DC	Alleged Perpetrator	Female	47 Year(s)
Other Household 2	Father	No Role	Male	35 Year(s)
Other Household 3	Father	No Role	Male	36 Year(s)
Other Household 4	Mother	No Role	Female	30 Year(s)

LDSS Response

On 4/27/2017, the SC who was a medically fragile child passed away at 6:40 PM at the hospital. The SC had pulled out his tracheotomy tube and was unable to breath on his own. The SC was diagnosed with PKAN at age 3 and had in home care. The SC required 24-hour supervision and the SM coordinated his care with three care aides and herself. Several days after the SC's passing, on 5/3/2017, the SCR received a report with allegations of DOA/Fatality, LS and IG against the care aide for the SC. At the time of the reported fatality the SM and the SF were listed with unknown roles. There were three chn listed in the report age 9, age 13 and age 6 also with unknown roles. A joint investigation was initiated by CCDSS and LE. It was learned that two of the chn were SSs age 9 and age 13. The third child listed age 6 was a cousin to the SC. The SM and SF were awarded full custody of the cousin through an Article 6 petition on 8/14/2014. CCDSS appropriately added the BF and the BM of the cousin to the report. CCDSS located and attempted to contact the SC's BF through out the investigation.

CCDSS assessed the safety of the SSs and the cousin within 24 hours. CCDSS did an assessment of the home and found there were no other safety concerns. During the investigation CCDSS interviewed the source. SCR and criminal history check were completed and reviewed. The SM and SF were questioned regarding drug and alcohol use. The SSs and the cousin were interviewed and observed. All appropriate collateral contacts were made including pediatricians, health care professionals and schools. Medical documentation about the SC was obtained and reviewed. It was learned that the family had cameras in the SC's room, they were always on. There were monitors in the SM and SF bedroom, so they could monitor the SC from their room. The monitors did not have any sound. CCDSS and LE obtained the video footage from that day and could determine a time line of the events as they unfolded. CCDSS also requested and viewed both the care aide's phone and the SM's phone. CCDSS confirmed that the care aide did text and call the SM before leaving at 6 AM. The interviews revealed that the SM and the SF had agreed to and had prior knowledge that the care aide had to leave by 6 AM that morning. It was also part of the contract that the care aides were not allowed to go upstairs. CCDSS appropriately added allegations of DOA/Fatality, LS and IG against the SM and the SF for the SC. There was no autopsy completed as the SM declined. The death certificate listed the immediate cause of death as complications of Pantothenate Kinase-Associated Neurodegeneration.

CCDSS appropriately Sub the allegations of DOA/fatality, LS and IG against the SM and the SF for the SC. The SM and the SF failed to provide adequate supervision for the SC by leaving the SC alone unsupervised knowing that the SC had been pulling out the tracheotomy tube which was connected to his breathing apparatus. The SC required this to breathe. The SC was unable to breathe on his own due to his medical diagnose. The care aide had to leave at 6 AM and had both texted the SM and called her before leaving the home. The video clearly showed the care aide leaving at 6 AM and the SM and SF did not come down until 7:38 that morning. The video showed the SC stopped moving at 6:50 AM after pulling out the tube. CCDSS Unsub the allegations of DOA/Fatality, LS and IG against the care aide for the SC.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

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?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041150 - Deceased Child, Male, 16 Yrs	041156 - Other - Aide for the DC, Female, 47 Year(s)	DOA / Fatality	Unsubstantiated
041150 - Deceased Child, Male, 16 Yrs	041156 - Other - Aide for the DC, Female, 47 Year(s)	Lack of Supervision	Unsubstantiated
041150 - Deceased Child, Male, 16 Yrs	041154 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
041150 - Deceased Child, Male, 16 Yrs	041154 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
041150 - Deceased Child, Male, 16 Yrs	041157 - Stepfather, Male, 35 Year(s)	DOA / Fatality	Substantiated
041150 - Deceased Child, Male, 16 Yrs	041157 - Stepfather, Male, 35 Year(s)	Lack of Supervision	Substantiated
041150 - Deceased Child, Male, 16 Yrs	041156 - Other - Aide for the DC, Female, 47 Year(s)	Inadequate Guardianship	Unsubstantiated
041150 - Deceased Child, Male, 16 Yrs	041157 - Stepfather, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
041150 - Deceased Child, Male, 16 Yrs	041154 - Mother, Female, 34 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐

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: There was no completed 7 safety assessment completed in CONNECTIONS. The 30 day report was a couple of days late and was not submitted for approved on time.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐

Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: None of the SSs needed to be removed as a result of the fatality.				

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: CCDSS offered bereavement services. The family refused the services. The SM stated she was in counseling but would not sign a release.							

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:
CCDSS offered services but family refused.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
CCDSS offered services but family refused.

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? Yes
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

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)
06/20/2014	Other Child - cousin of DC, Female, 3 Years	Other Adult - Parent Sub, Male, 24 Years	Excessive Corporal Punishment	Indicated	No
	Other Child - Cousin DC, Female, 5 Years	Mother, Female, 29 Years	Inadequate Guardianship	Indicated	
	Other Child - cousin of DC, Female, 3 Years	Mother, Female, 29 Years	Inadequate Guardianship	Indicated	
	Other Child - cousin of DC, Female, 3 Years	Other Adult - Parent Sub, Male, 24 Years	Lacerations / Bruises / Welts	Indicated	
	Other Child - cousin of DC, Female, 3 Years	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Indicated	
	Other Child - cousin of DC, Female, 3 Years	Mother, Female, 29 Years	Lacerations / Bruises / Welts	Indicated	
	Other Child - cousin of DC, Female, 3 Years	Other Adult - Parent Sub, Male, 24 Years	Inadequate Guardianship	Indicated	
	Other Child - Cousin DC, Female, 5 Years	Other Adult - Parent Sub, Male, 24 Years	Inadequate Guardianship	Indicated	
	Other Child - Cousin DC, Female, 5 Years	Mother, Female, 29 Years	Parents Drug / Alcohol Misuse	Indicated	

Report Summary:
SCR report received on 6/20/2014, stating that three-year-old cousin (other child named in fatality report) to the SC, defecated on herself. As a form of punishment, a parent substitute at the time the above dated report used excessive force

to the child. Thus, the cousin had extensive bruises to her buttocks. LE was called. The roles of the BM (PA to the SC) was unknown.

Determination: Indicated | **Date of Determination:** 08/29/2014

Basis for Determination:
The cousin and her sister were interviewed and both stated that the Parent Sub spanked her. The cousin was observed to have bruises on her buttocks. LE interviewed but no arrests were made. On the same evening the SCR report came in the BM of the cousin was arrested for a DWI. BM was going to jail and being evicted from her apartment. The BM planned for her chn and gave custody of the cousin to SF (her brother). Full custody was awarded to the SF and the SM on 8/14/2014. The allegations for IG, L/B/W and XCP were Sub against the Parent Sub for the cousin and the allegations of IG and PD/AM was Sub against the BM for cousin. The case was IND and closed-referred to community based services.

OCFS Review Results:
OCFS found that TCDSS made the appropriate determination based on the information gathered during the investigation. The history case was a Tompkins County INV.

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

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

1/31/2004-Allegations of IG and PD/AM were SUB against the Other Sub (BM in this report) for her chn.
2/5/2007-Allegations of IG and LS were Sub against the SM and the SF for all of the SSs.
11/5/2011-Allegations of IG, PD/AM and IF/C/S against the BM of the Other child named in the fatality INV. Case was changed to the FAR track and closed.
6/5/2013-Allegations of IG and L/B/W were UNF against the Other Sub(BM in the report) for her chn.

Known CPS History Outside of NYS

There was no known 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.

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