Child Fatality Report

Report Identification Number: NY-16-127

Prepared by: New York City Regional Office

Issue Date: Jun 30, 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	

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: 2 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 12/07/2016
Initial Date OCFS Notified: 12/07/2016

Presenting Information

On 12/7/16, the SCR registered a report that alleged the mother placed the 1-and 2-year-old children in a crib at 6:00 A.M. and left the home at 8:30 A.M. to run errands. The father was left to care for the children. The report stated the mother returned to the home at about 11:30 A.M. and at 12:00 P.M., she and the father went to the bedroom to check the children. The report alleged that when the parents opened the door of the bedroom, it was filled with steam and an inch of water from a radiator. The report stated the parents carried the children out of the apartment screaming for help and the FDNY responded to the home. The EMS transported the children to Lincoln Hospital where they were pronounced dead at 12:20 P.M.

The report stated the children were pulseless, covered in burns, purple with ashen skin and their extremities were rigid which is an indication they were deceased over an unknown period of time.

Executive Summary

Following the receipt of the fatality report ACS continued the investigation of the report dated 11/26/16 and conducted the interview for the reports simultaneously.

ACS contacted the NYPD, FDNY and the NYC Office of the Chief Medical Examiner (ME) who determined the deaths of the SC were accidental based on the poor upkeep of the building where the NYC Department of Homeless Services (DHS) placed the family for temporary housing.

ACS also interviewed neighbors who reported similar complaints concerning the faulty radiator valves in their apartments which the landlord had failed to repair. ACS questioned the neighbors about the level of care the parents provided the SC and the neighbors stated there were had no concerns regarding the care the parents provided the SC. According to ACS documentation, the neighbors said the children were always well-groomed and with their parents.

According to the parents, the mother left the home at about 8:30 A.M. in order to obtain insurance for a car they had recently purchased. Prior to leaving the home, the mother woke up the father at about 6:30 A.M. because the radiator valve in the living room had “shot off” the radiator. The father said he put the valve back on the radiator and went back to sleep. When the mother returned to the shelter, the father told her the children were asleep. However, when they opened the bedroom door to check the SC, it was full of white smoke. The parents said they grabbed the children and banged on neighbors' doors asking for assistance.

Medical providers and the children's medical records indicated the children were well cared for as the parents kept appointments and their immunizations were current.

ACS learned the parents had resided in Maine prior to coming to New York and were known to the child welfare system for domestic violence and drug abuse. In addition, the father had other children that were not in his care and cases of DV with other women out of state.

After the children’s deaths, the parents contacted an attorney who advised them to cease communication with ACS.

ACS unsubstantiated the allegations of the report.

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?** N/A

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:

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Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/07/2016 **Time of Death:** 12:20 PM

County where fatality incident occurred: BRONX
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? N/A
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: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 2
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

Following the fatality report, ACS continued the investigation of the SCR report dated 11/26/16 simultaneously.

ACS contacted the NYPD, FDNY and the NYC Office of the Chief Medical Examiner (ME) who determined the children died as the result of an accident -based on the poor upkeep of the building where the NYC Department of Homeless Services (DHS) placed the family for temporary housing.

ACS also interviewed neighbors who reported similar complaints concerning faulty radiator valves in their apartments which the landlord had failed to repair. ACS questioned the neighbors about the level of care the parents provided the SC and the neighbors stated there were no concerns regarding the care the parents provided the children. According to ACS' documentation, the neighbors said the children were always well-groomed and with their parents.

According to the parents, the mother left the home at about 8:30 A.M. in order to obtain insurance for a car they had recently purchased. Prior to leaving the home, the mother woke up the father at about 6:30 A.M. because the radiator valve in the living room had “shot off” the radiator. The father said he put the valve back on the radiator and went back to sleep. When the mother returned to the shelter, the father told her the children were asleep. However, when they opened the bedroom door to check the children, it was full of white smoke. The parents said they grabbed the children and banged on neighbors' doors asking for assistance.

Medical providers and the children's medical records indicated the children were well cared for as the parents kept appointments and their immunizations were current.

ACS learned the parents resided in Maine prior to coming to New York and were known to the child welfare system for domestic violence and drug abuse. In addition, the father had other children that were not in his care and cases of DV with

other women out of state.

After the children's deaths, the parents contacted an attorney who advised them to cease communication with ACS.

ACS unsubstantiated the allegations of the report.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?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
036443 - Deceased Child, Female, 1 Year(s)	036446 - Father, Male, 35 Year(s)	Burns / Scalding	Unsubstantiated
036443 - Deceased Child, Female, 1 Year(s)	036445 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
036443 - Deceased Child, Female, 1 Year(s)	036446 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
036443 - Deceased Child, Female, 1 Year(s)	036446 - Father, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
036443 - Deceased Child, Female, 1 Year(s)	036445 - Mother, Female, 24 Year(s)	Burns / Scalding	Unsubstantiated
036443 - Deceased Child, Female, 1 Year(s)	036445 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
037461 - Deceased Child, Female, 2 Year(s)	036445 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
037461 - Deceased Child, Female, 2 Year(s)	036446 - Father, Male, 35 Year(s)	Burns / Scalding	Unsubstantiated
037461 - Deceased Child, Female, 2 Year(s)	036446 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
037461 - Deceased Child, Female, 2 Year(s)	036446 - Father, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated

037461 - Deceased Child, Female, 2 Year(s)	036445 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
037461 - Deceased Child, Female, 2 Year(s)	036445 - Mother, Female, 24 Year(s)	Burns / Scalding	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?	☒	☐	☐	☐

Additional information:
There were no surviving children.

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	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 parents refused ACS' offer for burial and financial assistance. There were no other children in this household and the parents' legal counsel advised them to stop speaking with ACS.

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 are no surviving siblings in this household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate services needed for the parents. ACS did offer bereavement counseling and financial assistance for the cost of the funeral, however, the parents refused the services.

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

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)
11/25/2016	16151 - Deceased Child, Female, 2 Years	16153 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	Yes
	16151 - Deceased Child, Female, 2 Years	16154 - Father, Male, 35 Years	Inadequate Guardianship	Unfounded	
	16151 - Deceased Child, Female, 2 Years	16153 - Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unfounded	

Report Summary:
On 11/25/16, the SCR received a report alleging the mother would take the 11-month-old SC to dangerous areas near busy train stations, in the cold weather, to play the guitar for money. ACS learned the mother was seen near busy train stations on several occasions with the SC. The parents informed ACS the mother would do this to add to the family's income and would stay out for 2 to 3 hours.

Determination: Unfounded | **Date of Determination:** 01/20/2016

Basis for Determination:
ACS unsubstantiate the allegations of IF/C/S of the 11 month old SC by the mother and IG of the SC by the parents. However, ACS did not provide a narrative to support this decision or explained how the evidence applied to the legal definition of abuse and maltreatment.

ACS had information provided by the NYPD that noted this was not an isolated incident the locations selected by the mother to play her guitar were highly trafficket and dangerous.

OCFS Review Results:
NYCRO's review revealed ACS did not complete a thorough investigation and did not consider information gathered during the investigation when making a determination. The questions in the RAP were not documented in the notes to reflect thorough assessment of risk was completed. Collateral contacts were not made with social services in Maine or relevant family members.

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

Issue:
Appropriateness of allegation determination

Summary:
ACS did not consider the information provided by the NYPD concerning the arrears the mother was taking the 1 year old to play her guitar for money. The NYPD indicated this was not an isolated incident and the area was unsafe for the SC.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
ACS did not contact relatives or the Department of social services in Maine to adequately assess the family's circumstances and explore the reason they relocated to New York.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS did not address all the questions listed in the RAP. The family was homeless and had no relatives in NYS for support. The mother was placing the 1 year old SC at risk of harm to supplement the household income. A financial assessment and the parents' ability to care for the children while under the methadone treatment was crucial based on the circumstances in this case.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/25/2016	15057 - Deceased Child, Female, 3 Months	15060 - Father, Male, 34 Years	Inadequate Guardianship	Unfounded	Yes
	15057 - Deceased Child, Female, 3 Months	15059 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The SC were in the care of their BF while the BM was at Beth Israel Hospital (BIH). The BF contacted the BM because the 3-month-old who had a medical condition was crying for 3 hours and he did not know what to do to calm the SC. The BM called 911 from BIH; however, when EMS arrived at the shelter, the SC had fallen asleep and the BF did not want to awake the children to go to the hospital with EMS. The NYPD responded to the home and insisted the SC had to be taken

to the hospital. Therefore, the parents decided the BF would stay home with the 14-month-old SC while the BM met EMS at Lincoln Hospital. The 3-month-old was medically cleared and discharged to the BM.

Determination: Unfounded | **Date of Determination:** 03/25/2016

Basis for Determination:
ACS unsubstantiated the allegation of Inadequate Guardianship of the 3-month old SC by the parents. ACS determined the father demonstrated adequate care of the SC and the mother was very supportive of the family.

OCFS Review Results:
NYCRO's review found that ACS made contact with the family within the required time frame and assessed the SC were safe in the care of the parents.

ACS did not complete a thorough investigation to properly assess the family's circumstances. ACS documented concerns about the parents' methadone treatment based on the information gathered, but did not discuss these with the CASAC consultant when given the opportunity to discuss the case or request a medical consultation. The source and other relevant collaterals were not contacted.

ACS did not complete adequate safety assessments.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The selected safety decision noted safety factors were present that placed the children in immediate and impending danger of serious harm. However, there were no safety factors listed to support the decision nor was there a safety plan completed. The comments noted for other safety factors did not clearly state how these factors impacted the parents ability to care, supervise or protect the SC.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The documentation of this investigation did not reflect the questions listed in the RAP were properly addressed and/or explored. In addition, some responses were incorrect.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The documentation did not reflect ACS spoke to the source of the report, the children's pediatrician, shelter staff, MGM or the visiting nurse.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
The concerns about the parents methodone treatment were not fully explored or discussed with the CASAC. There was no clarity as to why the family was homeless or whether they had any CPS history in any other state.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and 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.

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

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

Known CPS History Outside of NYS

ACS obtained information from the Maine Department of Human Services Bureau of Child and Family Services of Alleged Child Abuse, which revealed the family had three prior cases in ME dated 4/14/14, 3/21/15 and 7/7/15.

The 2014 report involved concerned the mother's use of heroin and opiates while eight weeks pregnant with the oldest SC. The mother went to the ER complaining of abdominal pain and because she had no children, she was offered unspecified services.

On 3/21/15, there was a report concerning domestic violence between the parents. The father assaulted the mother by pushing her down some stairs and punching her in the face while she was holding the then four-month-old SC in her arms. The case was indicated against the father and a warrant was issued for his arrest. The father was not apprehended because he fled the state.

On 7/7/15, the family was reported for attempting to flee from Maine due to the father having an active warrant for his arrest. The parents were trying to seek shelter throughout ME, but fled after becoming aware the police were still seeking to arrest the father for the assault that occurred in March of 2015.

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