Child Fatality Report

Report Identification Number: NY-22-057

Prepared by: New York City Regional Office

Issue Date: Jan 20, 2023

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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 08/01/2022
Initial Date OCFS Notified: 08/01/2022

Presenting Information

An SCR report was received which alleged that on 8/1/22, around 10:55AM, the 1-month-old subject child was found unresponsive in the mother's bed. The mother called 911 immediately. The mother and her partner were sleeping in the bed with the child at the time. The roles of the grandmother, uncle, and other child were unknown.

Executive Summary

On 8/1/22, ACS received a report regarding the death of the 1-month-old female subject child who died on the same date. At the time of the child's death, she resided at home with her mother, the mother's partner, maternal grandmother, maternal uncle, and 1-year-old sibling. The subject child and sibling had different fathers; neither father was involved in the children's lives and both were uncooperative with ACS. The family was known to ACS as there was an open Preventive Services case at the time of the subject child's death, which had been open since 2011, as well as multiple historical investigations.

The investigation revealed the subject child was placed to sleep on a Boppy pillow on 7/30/22 around 11:00PM. In the morning, the mother found the child unresponsive and called 911 around 10:50AM. First responders arrived at the home at 11:07AM and began resuscitative efforts. The child was transported to the hospital where she was pronounced deceased at 11:23AM.

ACS coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the final autopsy report was not yet received at the time this report was written. The law enforcement investigation was closed, finding no criminality.

ACS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, community-based service providers, and relatives. ACS provided fatality-related services to the family upon receipt of the fatality report. Preventive Services remained ongoing following the determination of the investigation and the mother was engaged in community-based services including, trauma based therapy, mental health counseling, and homemaking services.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to 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?** No

Explain:
Casework activity was commensurate with best casework practice.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework was commensurate with case circumstances. The case remained open for Preventive Services at the time this report was written.

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 did not indicate IG against the mother and her partner; however, the definition of IG included imminent danger of such harm. The mother and partner co-slept with the subject child as well as having multiple items in the bed at the time.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/01/2022 **Time of Death:** 11:23 AM

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

Child Fatality Report

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 10:50 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

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	Female	1 Month(s)
Deceased Child's Household	Grandparent	No Role	Female	52 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	20 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Father	No Role	Male	20 Year(s)

LDSS Response

On 8/1/22, ACS received the SCR fatality report regarding the subject child. Upon receipt of the fatality report, ACS initiated their investigation within 24 hours and coordinated efforts with their MDT. ACS reviewed the family's history, which revealed significant CPS involvement, including an open services case unrelated to the fatality.

ACS interviewed the mother who was initially confrontational with ACS. The mother allowed ACS to assess the sibling but refused to address safe sleep practices and would not engage further. ACS made another attempt to interview the mother. During the second attempt, the mother reported she and her partner were sleeping in a full-sized bed with the subject child. She reported that she and her partner regularly co-slept with the subject child while the sibling slept in a bassinet adjacent to the bed. The mother reported there was a sheet on the bed and the child was placed atop a Boppy pillow to sleep. The mother showed ACS a Pack N Play, which had been provided by the department but had not been set up and was still in the box. A safe sleep environment was not observed for the subject child. A Pack N Play was observed for the sibling and the sibling was assessed to be safe in the care of the mother. The mother's partner corroborated the information but reported he was not present when the child was found unresponsive. The mother's partner refused to engage further with ACS.

ACS interviewed first responders who arrived to the home at 11:07AM to find the subject child in cardiac arrest. First responders administered CPR and transported the child to the hospital. First responders reported there were no notable concerns at the home, other than the alleged unsafe sleep environment. The mother reported to medical personnel and first responders that she last observed the child alive at 5:00AM, during a routine feeding. ACS spoke with the hospital

physician who reported the subject child arrived at the hospital around 11:00AM via EMS transport. The child was observed to be free from suspicious or abusive injuries but had blood pooled at the back of the head, indicating the child died and was on her back for a period of time. The emergency room physician reported it was unknown how long the child had been deceased, though assumed it was longer than the 5:00AM timeframe the mother provided. Preliminary findings from the medical examiner revealed there was no trauma or abuse to the subject child. Findings noted that the co-sleeping environment did not contribute to the child's death.

ACS attempted to interview family members who resided in the home, including the grandmother and uncle; however, family members refused to engage. Other collateral sources reported no concerns for the mother's care of the children.

ACS made efforts to locate and interview the fathers of the children. The mother reported they were not in the children's lives and had no contact with the children. Notification letters were sent, though attempts to contact the fathers were unsuccessful.

ACS met with their legal department and requested to file a neglect petition against the mother for the surviving sibling. The matter was delayed, and it was determined there was not sufficient evidence to form a cause of action for abuse or neglect. ACS filed a request for court ordered services in family court on 8/4/22, however, the request was rejected. The family continued working with preventive services on a voluntary basis at the time of this writing. ACS determined there was no credible evidence to substantiate the allegations of Inadequate Guardianship and DOA/Fatality against the mother and her partner regarding the subject child, despite the unsafe sleep environment. ACS determined that, given the lack of complete forensic information, they were unable to say with certainty that the child's death was the result of an unsafe sleep environment. Community-based services related to the fatality were declined by the family.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062182 - Deceased Child, Female, 1 Mons	062183 - Mother, Female, 18 Year(s)	DOA / Fatality	Unsubstantiated
062182 - Deceased Child, Female, 1 Mons	062183 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
062182 - Deceased Child, Female, 1 Mons	062185 - Mother's Partner, Male, 20 Year(s)	DOA / Fatality	Unsubstantiated
062182 - Deceased Child, Female, 1 Mons	062185 - Mother's Partner, Male, 20 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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:

Relevant collateral sources were interviewed. Efforts to locate and interview the biological fathers of the subject child and sibling were unsuccessful.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The mother was engaged in preventive services prior to the death of the subject child. Ongoing support was provided following the death.

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:
There was no removal regarding the surviving sibling.

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Preventive Services							
Additional information, if necessary: ACS provided Preventive Services to the family prior to and following the death of the subject child. The mother was in receipt of homemaking services and parenting skills education. The family was referred to community-based services related to the fatality.							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
Preventive services continued for the sibling. Fatality-related services were not deemed necessary due to the sibling's age and cognitive functioning.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother remained engaged in preventive services following the death. Community-based referrals related to the fatality were provided.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With neither of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/17/2022	Sibling, Male, 9 Months	Mother, Female, 17 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
ACS received a report from the SCR alleging that, for several months, the mother left the 9-month-old sibling in the care of the grandmother without making an adequate plan for his care. The mother was not reachable and provided no timeframe for her return. The mother left the sibling in the care of the grandmother despite the grandmother's inability to care for the sibling in the past.

Report Determination: Unfounded **Date of Determination:** 04/18/2022

Basis for Determination:
ACS determined there was no credible evidence to support the allegation of Inadequate Guardianship against the mother regarding the sibling. The investigation revealed the grandmother helped the mother care for the sibling due to the mother's need for additional support as she was a teenaged mother. The family was working with Preventive Services at the time of the investigation and had the support of many different service providers.

OCFS Review Results:
ACS completed case objectives within the required timeframes and spoke with relevant collateral sources. ACS did not consider all RAP elements. The RAP was scored that the mother did not have a diagnosed mental illness despite the record reflecting the mother was in receipt of mental health treatment for her diagnosed mental health condition. Further, the RAP was scored that the grandmother did not have a debilitating physical illness despite the record revealing that the grandmother had a congenital disease causing significant impairment of motor function.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP was scored that the mother did not have a diagnosed mental health condition; however, the record revealed the mother was in treatment for her diagnosed mental health. It was also noted that the grandmother did not have a physical impairment, despite documentation that the grandmother suffered from a congenital condition causing severe immobility.

Legal Reference:
18 NYCRR 432.2(d)

Action:
ACS will consider all risk elements identified throughout the course of the investigation and accurately document such

elements into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/23/2021	Sibling, Male, 3 Months	Mother, Female, 17 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 3 Months	Mother, Female, 17 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
ACS received a report from the SCR alleging the mother was using illicit substances while caring for the then 3-month-old sibling. The mother was irrational and unable to care for the sibling while under the influence. The mother left the sibling with the grandmother for days without making a plan for his care. The grandmother was disabled and unable to appropriately care for the sibling.

Report Determination: Unfounded **Date of Determination:** 09/29/2021

Basis for Determination:
ACS determined there was no credible evidence that the mother was under the influence of any substances while caring for the sibling. The mother was observed by ACS to be coherent and appropriate in her care of the sibling. The mother submitted to a drug test during the investigation and tested negative for all substances.

OCFS Review Results:
ACS completed case objectives within the required timeframes, made a referral to Early Intervention for the sibling, provided community-based referrals for a substance evaluation and corresponding treatment, and contacted relevant collateral sources. Safe sleep education was provided and discussed in depth during each home visit. Once case objectives were met, ACS appropriately determined the investigation. Preventive Services were continued as the family had an open case prior to the investigation.

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

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 05/13/2011

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐

Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: A contract agency provided additional support and services.				

Preventive Services History

A family services stage (FSS) was opened in 2011 and remained open at the time this report was written. The FSS was initially opened to provide support to the grandmother due to behavioral concerns for the mother and now deceased aunt.

Ongoing support and services were deemed necessary when the mother gave birth to the sibling on 5/19/21. ACS and a contract agency provided the mother with parenting skills education and intensive trauma therapy due to the death of the minor aunt. The FSS remained open following the death of the subject child for additional support and trauma based therapy.

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