NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SV-15-019 **Prepared by: Spring Valley Regional Office**

Issue Date: 2/5/2016

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
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		

Case Information

Report Type: Child Deceased
Age: 8 year(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 05/13/2015
Initial Date OCFS Notified: 05/13/2015

Presenting Information

Three weeks ago, the subject child's mother, who has issues with alcohol and drug use, left the eight-year-old subject child with the grandmother. Subject child had hyperthyroidism and required medication, but the mother did not provide the grandmother with any medication for the child. The grandmother, aware of the child's medical condition, did not provide any medical care for the child until May 12th at 11:30PM when she brought the subject child to the hospital for treatment. On May 13th 2015 at 5:27AM, the subject child died at the hospital of respiratory arrest secondary to a thyroid storm.

Executive Summary

On 05/13/2015, an SCR report was received by the Suffolk County Department of Social Services (SCDSS) with allegations of Inadequate Guardianship, Lack of Medical Care and Parent's Drug/Alcohol Misuse against the Subject Mother (SM) and Inadequate Guardianship and Lack of Medical Care against the Maternal Grandmother (MGM) after the MGM brought the subject child (SC) to the hospital in the midst of a thyroid storm. Several hours later, the SCR received a subsequent report with allegations of Inadequate Guardianship, Lack of Medical Care and DOA/Fatality against the SM and MGM after the SC passed away. There were no surviving siblings. The cause of death was determined to be Thyrotoxicosis (Thyroid Storm). Pneumonia was listed as a contributing factor in the death and the manner of death was determined to be natural.

The CPS investigation established that, on the morning of 05/12/2015, the MGM observed that the SC was running a fever. By the evening, the MGM noticed that the SC's breathing was different. The SC adjusted her breathing when asked about it. Later in the evening, the SC's breathing appeared worse and the MGM brought her to the hospital. The medical records indicated that when the SC was evaluated at the hospital, she was in a thyroid storm, a severe, life-threatening condition caused by an excess of thyroid hormone. Approximately six hours after being brought to the hospital, the SC died of respiratory arrest secondary to a thyroid storm. The MGM reported that the SC had been staying at her home for approximately 12 days and did not have her medication during that time.

SCDSS held and thoroughly documented fatality conferences at key points during the investigation. The case documentation throughout the life of the case was comprehensive and accurate. The investigation established that the SM, concerned about her sobriety, brought the SC to the MGM's home after spending one night at another family member's home. The SC did not have any clothing or medication when she arrived and SM left without advising anyone of her whereabouts. MGM spoke to SM several times regarding the missing medication but it was not located. Beyond this, neither the SM nor MGM took any steps to obtain and provide SC with the required medication. MGM was well aware of SC's thyroid condition as she had acted as a caretaker for the SC on several occasions in the past and had taken the SC to her doctor's appointments as well. Documentation showed that the SM had also not taken SC for her most recent follow-up visit with the endocrinologist as recommended. On 07/08/2015, SCDSS determined that there was credible evidence to substantiate the subsequent report allegations of Inadequate Guardianship, Lack of Medical Care and DOA/Fatality against both the SM and the MGM. The initial SCR report's allegations of Inadequate Guardianship and Lack of Medical care against the SM and MGM were substantiated as well. The allegation of Parent's Drug/Alcohol Misuse against the SM was unfounded. Although the SM

acknowledged using illegal drugs, there was no evidence that she was impaired while caring for the SC. Both reports were indicated and closed, as there were no surviving children. SCDSS' investigation was thorough and all allegations were properly determined, based on the information gathered. OCFS is in agreement with the determination of the allegations.

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:
n/a

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:
n/a

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: 05/13/2015 **Time of Death:** 05:27 AM

County where fatality incident occurred: SUFFOLK
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No

At time of incident leading to death, had child used alcohol or drugs? No

Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes

Is the caretaker listed in the Household Composition? No

At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:

Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	8 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	60 Year(s)

LDSS Response

Upon receipt of the SCR report on 05/13/2015, SCDSS responded to the report of the fatality and conducted a visit to the MGM's home, where the SC had been staying. The Senior Caseworker (SCW) met with the SC's mother (SM) and the MGM at that time. The SCDSS investigation consisted of face to face interviews with the SM and MGM as well as both announced and unannounced visits to the MGM and SM's homes. Collateral contacts were attempted and/or made with the following: Soundex (criminal history) reviews, CPS history reviews, interviews with multiple family members, both adults and children, who reside with the MGM, observations of young children who reside with the MGM, Hospital staff, Suffolk County Police Department (SCPD), SC's school staff, Suffolk County District Attorney's Office, SC's pharmacy, SC's pediatrician and specialty doctor. Multiple attempts were made to locate SC's father, through research of child support records, a visit to last known address and a phone call to last known number.

Interviews with the SM revealed that on 04/29/2015, SM made a plan to take the SC to the MGM's house as she felt that she might use illegal drugs again. SM reports packing SC's clothing and medication and spending the night at another family member's home. The following day, 04/30/2015, SM dropped the SC off at the MGM's home and left. MGM reports that the SC arrived without clothing or medication so she bought the SC some clothing and contacted the SM several times regarding the location of the medication. SM was unaware of the location of the child's medication and neither the MGM or SM took any steps to locate or provide new medication to the SC. On the morning of 05/12/2015, SC was running a fever, which MGM believed was the flu. By the evening, SC's breathing worsened and MGM brought SC to the Emergency Room. Approximately six hours later, SC died of respiratory arrest secondary to a thyroid storm.

Documentation from the SC's specialty doctor showed that the SM did not comply with regular follow-up appointments for the SC. She was seen in February 2015 after a 10-month absence and then missed the recommended 6-week follow up in April 2015. During a home visit, SCW discussed SM's substance abuse history and SM reported that she has not used. SCW offered referrals for substance abuse support but SM stated that she was doing well and did not need them. On 06/05/2015, SCW spoke with a SCPD Detective who confirmed that the family had located the SC's medication and that the amount left was consistent with it being used as prescribed. The amount left in the bottle would have accounted for the days that the SC was staying with the MGM.

Although SM did make a plan for the SC to go to the MGM's house, SM did not respond appropriately to MGM's calls about the missing medication. Through those phone calls, SM was aware that the medication was missing and failed to pursue any action to obtain the medication. MGM had a history of caring for the SC when SM was incarcerated or impaired by drugs. MGM was aware of SC's medical condition and had taken her to several medical appointments in the past. Although MGM did contact SM regarding the missing medication, once the pills were not located, she failed to take further action by seeking medical treatment for SC until the evening before she died. All allegations in both reports, except Parent's Drug/Alcohol Misuse, were substantiated against the SM and MGM and the case was indicated and closed, as there were no surviving siblings.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
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 reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no Child Fatality Review Team in Suffolk County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
022181 - Deceased Child, Female, 8 Yrs	022183 - Grandparent, Female, 60 Year(s)	Inadequate Guardianship	Substantiated
022181 - Deceased Child, Female, 8 Yrs	022182 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
022181 - Deceased Child, Female, 8 Yrs	022182 - Mother, Female, 30 Year(s)	Lack of Medical Care	Substantiated
022181 - Deceased Child, Female, 8 Yrs	022183 - Grandparent, Female, 60 Year(s)	Lack of Medical Care	Substantiated
022181 - Deceased Child, Female, 8	022182 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated

Yrs			
022181 - Deceased Child, Female, 8 Yrs	022183 - Grandparent, Female, 60 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐

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	Offered, but	Offered, Unknown	Needed but not	Needed but	N/A	CDR Lead to

	Death	Refused	if Used	Offered	Unavaliable		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	☐	☐	☐	☐	☐	☒	☐

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?	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?	N/A
Was the child acutely ill during the two weeks before death?	Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR	Alleged	Alleged	Allegation(s)	Status/Outcome	Compliance

Report	Victim(s)	Perpetrator(s)			Issue(s)
03/13/2013	5912 - Deceased Child, Female, 6 Years	5911 - Mother, Female, 38 Years	Lack of Medical Care	Far-Closed	No
	5912 - Deceased Child, Female, 6 Years	5911 - Mother, Female, 38 Years	Inadequate Guardianship	Far-Closed	
	5912 - Deceased Child, Female, 6 Years	5911 - Mother, Female, 38 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Report Summary:
Since last school year, subject child has been having ear, nose and throat issues. The child also has sleep apnea, which is causing her to fall asleep regularly in class. The mother is aware and is failing to seek medical treatment for the child. As a result, the child is struggling academically and has severe behavioral problems in school. The mother is actively abusing crack cocaine. She would sometimes take the child with her when she goes out to do the drug or she would leave the home without notice for days at a time. The child would become upset when the mother leaves.

OCFS Review Results:
The FAR worker appropriately addressed issues related to school attendance, parental drug/alcohol misuse and inadequate guardianship. During the course of the FAR case, the mother was arrested and failed to make an adequate plan for the child's care. The FAR case was appropriately closed and a subsequent SCR report was generated.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/23/2013	5952 - Deceased Child, Female, 6 Years	5925 - Mother, Male, 38 Years	Lack of Medical Care	Indicated	No
	5952 - Deceased Child, Female, 6 Years	5925 - Mother, Male, 38 Years	Inadequate Guardianship	Indicated	

Report Summary:
On 04/22/2013 the mother was arrested on felony charges Grand Larceny 3rd, D Felony Possession of a Forged Instrument 2nd and E Felony Grand Larceny 4th Property Value more than $1000. The mother is currently incarcerated. The mother failed to make a plan for subject child and she did not follow through with recommendations made for Ears, Nose and Throat medical treatment.

Determination: Indicated

Date of Determination: 06/20/2013

Basis for Determination:
SCDSS' investigation revealed that the subject child was diagnosed with a neurological disorder and the mother did not follow up with medication management or counseling for the child. Child was also diagnosed with a sleep disorder, warranting follow up appointments and possible surgery. The mother did not follow up with these recommendations. The mother's failure to plan for the child has resulted in the family moving from place to place, causing a lack of stability, and the child was acting out and falling asleep in school on a regular basis.

OCFS Review Results:
OCFS is in agreement with the determination of the allegations.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/30/2013	5953 - Deceased Child,	5936 - Grandparent - Aunt's	Sexual Abuse	Unfounded	No

	Female, 7 Years	child, Female, 57 Years		
	5953 - Deceased Child, Female, 7 Years	5939 - Aunt/Uncle - Aunt's child, Female, 22 Years	Sexual Abuse	Unfounded
	5953 - Deceased Child, Female, 7 Years	5935 - Mother - Aunt's child, Female, 39 Years	Sexual Abuse	Unfounded
	5953 - Deceased Child, Female, 7 Years	5937 - Aunt/Uncle - Aunt's child, Female, 26 Years	Inadequate Guardianship	Unfounded
	5953 - Deceased Child, Female, 7 Years	5937 - Aunt/Uncle - Aunt's child, Female, 26 Years	Sexual Abuse	Unfounded
	5953 - Deceased Child, Female, 7 Years	5938 - Aunt/Uncle - Aunt's child, Female, 25 Years	Inadequate Guardianship	Unfounded
	5953 - Deceased Child, Female, 7 Years	5939 - Aunt/Uncle - Aunt's child, Female, 22 Years	Inadequate Guardianship	Unfounded
	5953 - Deceased Child, Female, 7 Years	5935 - Mother - Aunt's child, Female, 39 Years	Inadequate Guardianship	Unfounded
	5953 - Deceased Child, Female, 7 Years	5936 - Grandparent - Aunt's child, Female, 57 Years	Inadequate Guardianship	Unfounded
	5953 - Deceased Child, Female, 7 Years	5938 - Aunt/Uncle - Aunt's child, Female, 25 Years	Sexual Abuse	Unfounded

Report Summary:
On 10-29-2013 the subject child was brought to the ER because she had vaginal bleeding. The child had genital warts. The child has been in the care of the mother until 10-10-2013. The mother is now incarcerated. Since that date the grandmother had temporary custody. It is unknown how or when the child acquired the std. All the adults in the homes will be named as subjects in the report.

Determination: Unfounded | **Date of Determination:** 12/27/2013

Basis for Determination:
An investigation by SCDSS revealed that the grandmother took the child to the hospital immediately upon learning that she was bleeding and was cooperative with SVU and CPS. The child made no disclosure of sexual abuse and it was noted that she appeared credible. The hospital confirmed that the warts were caused by a virus and not necessarily sexually transmitted. They further stated the virus could be transmitted through contact and the mother confirmed that she has them as well and shared a washcloth with the child. It did not appear that the mother was aware that the warts could be transmitted to the child.

OCFS Review Results:
OCFS is in agreement with the determination of the allegations.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/05/2014	5954 - Deceased Child, Female, 7 Years	5944 - Grandparent - Aunt's child, Female, 57 Years	Lack of Medical Care	Unfounded	No

Report Summary:
7-year-old subject child has had a bead stuck in her ear since 1/11/14. The bead somehow got in her ear when she was playing with her cousin. Child was seen by her primary care physician on that day and was referred to a specialist. Grandmother did not follow through with this recommendation. Child is in pain frequently and is also putting things in

her ear to try to alleviate the pain.	
Determination: Unfounded	**Date of Determination:** 03/05/2014
Basis for Determination: Throughout the course of the investigation it was discovered that the child was taken to the doctor by the grandmother and the piece of plastic in her ear, originally thought to be a bead, was removed. Grandmother agreed to follow up with the child's specialist doctors as required.	
OCFS Review Results: OCFS is in agreement with the determination of the allegations.	
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No	

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

There were three SCR reports generated more than three years before the fatality:

On 03/02/1998, SCDSS received a report from the SCR alleging Educational Neglect against the MGM on behalf of the SM's siblings who were ages seven and eight at the time. The report alleged that the children had excessive absences and were failing academically as a result. During the course of the investigation, three more siblings were added to the report as well as allegations of Inadequate Food, Clothing, Shelter. On 10/20/1998, SCDSS substantiated all allegations against the MGM. The case was indicated and opened for court-ordered services.

On 01/12/2009, SCDSS received a report from the SCR alleging Inadequate Guardianship against the MGM on behalf of her grandson who was age eight at the time. The report alleged that the MGM used a hanger, belt, buckle and spoon to whip the child. On 03/10/2009, SCDSS unfounded the allegations against the MGM. The case was closed, citing no services required.

On 01/16/2011, SCDSS received a report from SCR alleging Inadequate Food, Clothing, Shelter and Inadequate Guardianship against the SM on behalf of the SC who was age five at the time. The report alleged that the child had dental and vision issues that were affecting her academically and emotionally. SM did not make any follow-up appointments for the SC. On 01/21/2012, SCDSS unfounded the allegations against the SM. The case was closed, citing no services required.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

Services Open at the Time of the Fatality

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.

Required Action(s)

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

Foster Care Placement History

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

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No