Report Identification Number: SV-17-047

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

Issue Date: Apr 12, 2018

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased **Jurisdiction:** Westchester **Date of Death:** 10/22/2017
Age: 7 month(s) **Gender:** Male **Initial Date OCFS Notified:** 10/23/2017

Presenting Information

An SCR report was received on 10/22/17 regarding the death of the 7-month-old SC. The report alleged that on 10/12/17 the SC and 2-year-old SS were left unsupervised in a bathtub filled with water. The children were left alone by the babysitter (OA) for 2-3 minutes. The OA returned and found the SC unresponsive. The SF was in another room in the home and the OA began to yell, alerting him to the situation. They began CPR and called 911. The SC was taken to the hospital and admitted to the Pediatric Intensive Care Unit (PICU) for 10 days. On 10/22/17, the BM and SF were informed the SC had irreversible brain damage from drowning in the bathtub and there was no possibility he would recover. The BM and SF decided to end the SC's care after they were informed of this.

Executive Summary

On 10/22/17, Westchester County Department of Social Services (WCDSS) received an SCR report regarding the death of the 7-month-old SC. The fatality investigation was subsequent to an SCR report that was received on 10/12/17, regarding the incident that led to SC's death.

On 10/12/17, the OA was bathing the SC and 2 yo SS in a bathtub filled with water and the SC was in a flotation device. OA left the children unsupervised in the bathtub for a few minutes and returned to find the SC unresponsive with the side of his face in the water. OA screamed for SF, who called 911 and administered CPR until EMS arrived. SC was taken to the hospital via ambulance. SC remained on life support until 10/22/17, when it was determined SC would not recover from an irreversible brain injury as a result of drowning. Medical care was withdrawn by the parents and SC passed away at 12:16 PM.

The final autopsy report was not available for review at the time of this writing; the cause and manner of death were pending. Medical records showed the SC's condition was consistent with near-drowning. He was observed to have second degree burns in the armpit area, which were determined to have been caused by the warm packs EMS used during resuscitation attempts. It was noted SC had no other marks or signs of trauma on his body.

WCDSS assessed the safety of the 2 yo SS and he was determined to be safe in his parents' care. Attempts were made to fully interview SM, SF and OA. The SM and SF retained an attorney and would not cooperate with the investigation and OA was unable to be located. WCDSS conducted a joint investigation with LE. LE interviewed SF and OA and provided copies of the supporting depositions to WCDSS. LE completed their investigation and did not pursue charges against SF and OA. WCDSS contacted several other collaterals including the pediatrician, ME, hospital staff and EMS. WCDSS referred the family to victim services, although the parents did not cooperate with the referral.

WCDSS added and substantiated allegations of IG against SM and SF regarding the SC. The parents were improperly using the flotation device for SC's bath on a frequent basis. The allegations of IG and LS were substantiated against OA regarding SC and SS as well as DOA/Fatality regarding SC. OA's improper use of the flotation device in the bathtub full of water as well as her lack of supervision of the children lead to SC being found unresponsive and hospitalized. Due to the adults' failure to exercise a minimum degree of care, the SC suffered severe, irreversible neurological damage which led to his death. The case was closed because the parents were uncooperative with the investigation and legal action was deemed not necessary.

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:
The decision to indicate the investigation was appropriate.

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:
The decision to close the investigation was appropriate.

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: 10/22/2017 **Time of Death:** 12:16 PM

Date of fatal incident, if different than date of death: 10/12/2017
Time of fatal incident, if different than time of death: 11:00 AM

County where fatality incident occurred: Westchester

Was 911 or local emergency number called? Yes
Time of Call: 11:09 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: bathing

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 2 Minutes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was:

- ☐ Drug Impaired
- ☒ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	Male	7 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Other Adult - Babysitter	Alleged Perpetrator	Female	50 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

WCDSS began their investigation into the incident that lead to SC's death, after receipt of an SCR report on 10/12/17. WCDSS contacted the source and LE, and determined the parents and OA had no CPS or criminal history. WCDSS determined SF and SM had a family friend (OA) residing with them Monday-Friday to care for the SC and 2 yo SS while both parents worked.

WCDSS conducted a home visit and OA allowed them into the home; the first floor of the home was observed and contained no safety hazards. OA did not speak English and therefore an interview was not conducted at that time.

WCDSS located SM and SF at the hospital, spoke briefly with them and assessed the safety of the SS. SM stated she had used the flotation device approximately 10 times to give SC a bath, and was always there to supervise SC and SS in the bathtub. SM stated that she placed the SC on his stomach on the device with the straps fastened on him. SM denied that she was home at the time of the incident and said OA later told her what occurred. A temporary safety plan was initiated

that SS would not be left in the care of OA and would be supervised with SF until more information could be gathered. Full interviews were not conducted at that time at the request of LE. On 10/19/17, the parents informed WCDSS they had retained an attorney and refused to answer any additional questions. WCDSS's attorney contacted the parents' attorney to set up interviews, although attempts were unsuccessful. WCDSS made attempts to locate and interview the OA, although her address was unknown to LE or the parents, and she could not be located once she left the parents' home.

Supporting depositions were taken from the SF and OA by LE and provided to WCDSS. SF reported to LE he was working downstairs in the home and was aware the children were taking a bath upstairs. He heard screaming and went upstairs to find OA holding SC, who was not moving. SF called 911 and followed instructions for CPR until about 5 minutes later when the ambulance arrived. He reported OA was a family friend who came to help care for the children. OA was interviewed by LE with the assistance of a translator and reported she was giving SC and SS a bath in the master bedroom bathtub. SC was in a swim trainer flotation device with a shoulder harness. While the children were in the tub, she wiped down the stairs because SS had spilled milk on the stairs. She was gone for less than 2 minutes. While cleaning, SS called out to her saying he was finished taking a bath. She returned to the bathroom to remove SS from the tub and she observed SC's face submerged in the water. She removed SC from the tub, patted him on the back and called to SF for help. SF called 911 and SS got out of the tub and dressed himself. The children were in the tub for a total of approximately 20 minutes and the water was not too hot and at a comfortable temperature. OA reported caring for the children for a little over a month and lived with the family Monday-Friday. She said she bathed SC every day during this time. She knew the family for around 7 years.

WCDSS contacted the necessary collaterals and gathered sufficient documentation to support substantiating the allegations. The final autopsy report was not available for review at the time of the writing of this report, although hospital records showed SC's condition was consistent with near-drowning. There were no concerns for the SS remaining in the care of the parents and there were family members supporting them and assisting with the care of the SS. The family was referred to victim services, although the agency was unable to make contact with the parents to initiate services. There were no additional referrals for services sent and the case was closed due to the lack of cooperation from the parents.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or 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? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042348 - Sibling, Male, 2 Year(s)	044721 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
042348 - Sibling, Male, 2 Year(s)	044723 - Father, Male, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
042348 - Sibling, Male, 2 Year(s)	042351 - Other Adult - Babysitter, Female, 50 Year(s)	Inadequate Guardianship	Substantiated

042348 - Sibling, Male, 2 Year(s)	042351 - Other Adult - Babysitter, Female, 50 Year(s)	Lack of Supervision	Substantiated
044727 - Deceased Child, Male, 7 Month(s)	044721 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
044727 - Deceased Child, Male, 7 Month(s)	044723 - Father, Male, 32 Year(s)	DOA / Fatality	Unsubstantiated
044727 - Deceased Child, Male, 7 Month(s)	042351 - Other Adult - Babysitter, Female, 50 Year(s)	Inadequate Guardianship	Substantiated
044727 - Deceased Child, Male, 7 Month(s)	042351 - Other Adult - Babysitter, Female, 50 Year(s)	Lack of Supervision	Substantiated
044727 - Deceased Child, Male, 7 Month(s)	042351 - Other Adult - Babysitter, Female, 50 Year(s)	DOA / Fatality	Substantiated
044727 - Deceased Child, Male, 7 Month(s)	044721 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
044727 - Deceased Child, Male, 7 Month(s)	044723 - Father, Male, 32 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

Additional information:

WCDSS briefly spoke to SM and SF, although were unable to conduct full interviews due to the parents' lack of cooperation. OA was not interviewed by WCDSS as she could not be located, despite reasonable attempts.

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 an open CPS investigation at the time of the SC's death and the SS was seen on 10/12/17 as part of that investigation. On 10/19/17 the SF and SM informed WCDSS that they had retained an attorney and wanted any contact to go through the attorney. The parents were not cooperative with WCDSS at the intervals of these safety assessments.

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:
WCDSS was unable to fully assess risk to the SS or assess service needs due to the parents lack of cooperation and refusal to complete full interviews.

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?	☐	☒	☐	☐

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: Victim Services

Additional information, if necessary:
A referral was made for victim services, although the parents did not cooperate with the referral. Due to the parents' lack of cooperation with the investigation WCDSS was unable to offer services to the family.

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

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
SM and SF did not cooperate with the investigation.

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?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	Yes

Infants Under One Year Old

During pregnancy, mother:
- ☐ Had medical complications / infections
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☐ Used illicit drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:
- ☐ Drug exposed
- ☐ 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)	Status/Outcome	Compliance Issue(s)
10/12/2017	Deceased Child, Male, 7 Months	Father, Male, 32 Years	Burns / Scalding	Indicated	No
	Deceased Child, Male, 7 Months	Father, Male, 32 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 7 Months	Father, Male, 32 Years	Internal Injuries	Indicated	
	Deceased Child, Male, 7 Months	Father, Male, 32 Years	Lack of Supervision	Indicated	
	Sibling, Male, 2 Years	Father, Male, 32 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 2 Years	Father, Male, 32 Years	Lack of Supervision	Indicated	

Deceased Child, Male, 7 Months	Other Adult - Babysitter, Female, 50 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 7 Months	Other Adult - Babysitter, Female, 50 Years	Lack of Supervision	Indicated
Sibling, Male, 2 Years	Other Adult - Babysitter, Female, 50 Years	Lack of Supervision	Indicated
Deceased Child, Male, 7 Months	Mother, Female, 32 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 7 Months	Mother, Female, 32 Years	Lack of Supervision	Indicated
Sibling, Male, 2 Years	Mother, Female, 32 Years	Lack of Supervision	Indicated
Sibling, Male, 2 Years	Mother, Female, 32 Years	Inadequate Guardianship	Indicated
Deceased Child, Male, 7 Months	Other Adult - Babysitter, Female, 50 Years	Burns / Scalding	Indicated
Deceased Child, Male, 7 Months	Other Adult - Babysitter, Female, 50 Years	Internal Injuries	Indicated
Sibling, Male, 2 Years	Other Adult - Babysitter, Female, 50 Years	Inadequate Guardianship	Indicated

Report Summary:
An SCR report was received alleging that the 7-month-old SC and 2 yo SS were left unsupervised by an OA in a bathtub filled with water for 2-5 minutes. The SC was in a floatation device. The SF was also home at the time. When the OA returned she found the SC floating in the water and he was unresponsive. CPR was administered and SF 911 called. On the way to the hospital the SC went into cardiac arrest in the ambulance and was revived. The SC had 2 blisters on his chest and arm. The SC was admitted to the Pediatric Intensive Care Unit.

Determination: Indicated | **Date of Determination:** 12/08/2017

Basis for Determination:
WCDSS substantiated the allegations of IG and LS against SF and SM as they allowed OA to babysit the children without knowing her address, OA's lack of comprehension of the English language and therefore inability to take appropriate action in an emergency and they failed to advise OA of the appropriate use of the floatation device used in bath time. Allegations of II, IG and LS were substantiated against OA as she was not properly supervising the children during bath time. OA's poor judgment of using the flotation device and leaving the children alone for a period of 2 minutes placed the children at risk of harm and led to SC being found unresponsive. SC died as a result of his injuries.

OCFS Review Results:
WCDSS briefly interviewed SM and LE interviewed the SF and OA. Reasonable attempts were made to fully interview SM, SF and OA. The parents retained an attorney and did not cooperate with the investigation. OA could not be located. The SS and SC were observed. An appropriate safety plan was temporarily initiated until more information could be gathered regarding the incident leading to the SC's hospitalization. WCDSS contacted the pediatrician for the children who had no concerns. The hospital staff found the SC's injuries correlated with the events reported by the parents and it was determined the burns were caused by hot packs used by EMS.

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

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

There is no known CPS history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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

Action:	The supporting narrative in the investigation determination for the 10/12/2017 investigation was vague. It is recommended that WCDSS includes language that clearly supports findings and aligns with the case circumstances in each investigation determination.

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