Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-18-015

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

Issue Date: Aug 30, 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
Age: 11 year(s)
Jurisdiction: Orange
Gender: Male
Date of Death: 03/03/2018
Initial Date OCFS Notified: 03/03/2018

Presenting Information

An SCR report alleged on 3/3/18, while in the care and supervision of an unknown babysitter, SC passed away. At approximately 12:00 PM, the babysitter left SC home alone unsupervised for approximately an hour while she went to the store. SC had a developmental disability and had 2 cardiac surgeries in the past. While unsupervised, SC choked on a piece of food and went into cardiac arrest. SC was found deceased at approximately 1:00 PM by the babysitter, with dried vomit on his face. The last time SC was observed alive was just before noon by the babysitter. When the babysitter came home and saw SC, she attempted to revive him. When she was not successful, she contacted the family. The babysitter then called 911 and SC's body was brought to a medical center. Emergency Services were contacted at 1:30 PM. SM had an unknown role.

Executive Summary

On 3/3/18, the Orange County Department of Social Services (OCDSS) received an SCR report regarding the death of the 11 yo male SC. There was an open Preventive Services case at the time of SC's death, which opened 1/24/18, to assist SM with obtaining housing, employment, public assistance and services for SC's developmental disabilities. The case closed on 3/5/18, upon the death of SC.

The investigation revealed on 3/3/18 around 12:30 PM, the 13 yo babysitter found SC unresponsive on the floor in his bedroom. The 13 yo messaged SM through social media and told her she could not wake up SC. SM told the babysitter to touch SC's nose, which did not wake him up. SM contacted the 13 yo's adult male cousin, who arrived at the home and called 911 at 1:29 PM. He performed CPR until EMS and LE arrived. SC was transported to the hospital via ambulance and pronounced deceased at 2:01 PM. The 4 yo SS was in another room in the home at the time of the incident.

SC was developmentally delayed and had extensive medical issues that required the administration of daily medication and the use of a medical device while sleeping. SC was hospitalized several times in the past due to difficulty breathing and issues related to a heart condition. The investigation revealed SM was not home at the time of the incident. She had traveled to New Jersey on 3/2/18 and planned to return on 3/4/18. SM hired a 13 yo child to babysit the CHN. The 13 yo's adult female cousin stopped by to check on the CHN around 11:00 AM on 3/3/18. SC was in his bedroom and presumed to be sleeping when the cousin left the home around 12:00 PM.

An autopsy was performed and the cause of death was "group A streptococcal pneumonia complicating viral respiratory infection in patient with trisomy 21" with a contributory cause of death of "obesity with sleep apnea." The manner of death was "natural." The ME found no signs of abuse or trauma on SC's body. LE investigated the incident and there were no criminal charges as a result.

The SS and 13 yo were assessed to be safe in their mothers' care. SM agreed to utilize other appropriate caretakers for the SS. OCDSS' attempts to locate the BFs of the SS and the 13 yo were unsuccessful. SC's BF was unknown.

OCDSS completed a thorough investigation into the incident, contacted all necessary collaterals and received all appropriate records. OCDSS appropriately added and substantiated the allegations of IG and LS against SM regarding SC, SS and the 13 yo and LMC against SM regarding SC. It was determined the 13 yo babysitter was not an adequate caretaker for the CHN based on SC's medical issues and required medication administration. The 13 yo did not have a way to communicate with her BM or SM, other than through social media, as she was unaware there was phone in the

home. SM failed to contact the required medical specialists for SC when she moved to New York State from Maryland in October 2017. SC had significant cardiac and pulmonary issues that required follow up with a cardiologist and pulmonologist.

The allegations of DOA/Fatality against SM and DOA/Fatality, LS and C/T/S against the 13 yo's adult female cousin regarding SC were unsubstantiated. It was determined SC died from natural causes related to an illness and SM's and the 13yo's cousin's actions did not cause SC's death. It was determined the 13 yo's cousin was not responsible for the care of SC and SS at the time of the incident. There was no evidence gathered to support SC was left alone in the home or that he choked on food.

SM, SS, the 13 yo and her BM engaged in Special Assistance Trauma Unit (SATU) services. SM was referred for family educator services and funeral assistance, and the 13 yo's BM was referred for DV services. The case was opened for Preventive Services.

The Preventive Services case open at the time of the fatality was incorrectly coded as an Out of Town Inquiry. This practice has been discontinued and a corrective action is already in place.

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 case and open a Preventive Services case was appropriate.

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 activity was commensurate with circumstances and there was appropriate supervisory consultation throughout the case.

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: 03/03/2018 **Time of Death:** 02:01 PM

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

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: 01:29 PM
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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 8 Hours
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	11 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)
Other Household 1	Other Adult - Babysitter's BM	No Role	Female	39 Year(s)
Other Household 1	Other Child - Babysitter	Alleged Victim	Female	13 Year(s)
Other Household 2	Other Adult - Babysitter's BF	No Role	Male	39 Year(s)

Other Household 3	Other Adult - SS's BF	No Role	Male	30 Year(s)
Other Household 4	Other Adult - Babysitter's Cousin	Alleged Perpetrator	Female	24 Year(s)

LDSS Response

OCDSS reviewed SCR history and learned there was an open Preventive Services case in which SM was receiving assistance in obtaining services for SC, who had developmental disabilities and extensive medical concerns. SM and the CHN left Maryland to move to New York in October 2017 due to DV concerns with SS's BF. OCDSS contacted LE and learned SM was in New Jersey when the incident occurred. SM was notified about SC's death and was on her way back home. OCDSS observed SC's body in the hospital to have no marks or bruises and no visible trauma.

SM reported SC was often sick and required resuscitation in the past. He had a home tutor and was unable to attend school due to the severity of his needs. SM said SC was sick a few days prior to his death, with vomiting and diarrhea and had a fever and cough earlier in the week, which subsided with medication. He looked well and she had no reason to believe he was sick when she left. She paid a 13 yo child to watch the CHN while she went to New Jersey for 2 nights. SM's boyfriend's sister, who is cousins with the 13 yo, agreed to stop by and check on the CHN. SM left the home at 5:00 PM on 3/3/18 and was in contact with the 13 yo via social media that evening. The SS called and left her a voicemail at 6:05 AM on 3/4/18, that she listened to around 10:00 AM. SS stated SC was sick, coughing and threw up and she asked for SM to come home. SM received a message from the 13 yo at 10:30 AM, which mentioned the SS, then received a message at 12:30 PM that stated the 13 yo was unable to wake SC. SM directed her to touch SC's nose to wake him up, which didn't work. SM contacted the 13 yo's adult male cousin to go to the home. The male cousin arrived and called 911. She was on video chat with the 13 yo when LE and EMS arrived. She received a call from the hospital at 2:05 PM informing her SC had passed away. SM reported the BF of SC was unknown. SS's BF's location was unknown and SS had no contact with him since they moved to New York.

The 13 yo's female cousin said since her cousin was babysitting the CHN while SM was away, she agreed to check on them. She was in the home when SM left, stayed until 3:00 AM and then returned at 11:00 AM. When she arrived the 13 yo was in the living room with SS and SC was in his bedroom. She did not check on SC at that time as it was common for him to sleep late. She left the home around 12:00 PM and received a call from a friend that 911 had been called for SC.

The 13 yo reported she spoke to SM around 11:00 PM on 3/2/18 and told SM that SC complained of having a stomach ache and did not eat dinner. Around 4:00 AM she observed SC pass through the living room and go into the bathroom, then he went back to bed. At that time SC was coughing. At 6:30 AM SS came into the living room and said she had a bad dream. At 12:30 PM she entered SC's bedroom and observed him lying on the floor with his head propped up. He was wearing the mask from the machine he is required to use when he is sleeping and he appeared to be sleeping. She was unable to wake him and messaged SM. SM said her male cousin was on his way to the home so she didn't call 911. Her cousin arrived and called 911. The 13 yo denied her BM was aware she was babysitting the CHN. OCDSS spoke to her BM, who said she thought SM was home and she would not have allowed her to babysit the CHN due to her age.

The SS and 13 yo were assessed to be safe in the care of their mothers and both homes were assessed to be safe. SM agreed to utilize other caretakers for the SS. OCDSS appropriately indicated the case, made the necessary service referrals and opened a Preventive Services case.

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? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047181 - Deceased Child, Male, 11 Yrs	047182 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
047181 - Deceased Child, Male, 11 Yrs	047211 - Other Adult - Babysitter's Cousin , Female, 24 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
047181 - Deceased Child, Male, 11 Yrs	047211 - Other Adult - Babysitter's Cousin , Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
047181 - Deceased Child, Male, 11 Yrs	047211 - Other Adult - Babysitter's Cousin , Female, 24 Year(s)	Lack of Supervision	Unsubstantiated
047181 - Deceased Child, Male, 11 Yrs	047182 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
047181 - Deceased Child, Male, 11 Yrs	047182 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
047181 - Deceased Child, Male, 11 Yrs	047182 - Mother, Female, 30 Year(s)	Lack of Medical Care	Substantiated
047183 - Sibling, Female, 4 Year(s)	047182 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
047183 - Sibling, Female, 4 Year(s)	047182 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
047185 - Other Child - Babysitter, Female, 13 Year(s)	047182 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
047185 - Other Child - Babysitter, Female, 13 Year(s)	047182 - Mother, Female, 30 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:
Attempts to locate the SS's BF and the 13 yo's BF were not successful.

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?	☒	☐	☐	☐

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:
Risk was adequately assessed and a Preventive Services case was opened to provide the identified services.

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	☐	☐	☐	☐	☐	☒	☐

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:
SS engaged in SATU services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SM engaged in SATU services and funeral assistance was provided.

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?	No
Was the child acutely ill during the two weeks before death?	Yes

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

A Preventive Services case opened with Maryland Department of Human Services on 5/27/16 regarding SM and her CHN. The school referred the family for in-home services from the Interagency Family Preservation Unit for homelessness and housing issues, limited resources, a history of DV, transportation issues, SM's MH concerns and assistance in managing SC's developmental disability and medical issues. The Preventive Services case closed on 6/3/16, after SM was incarcerated for assaulting SS's BF during a DV incident. SS went to live with her BF and SC went to live with the MGM.

A CPS report dated 7/3/17 was investigated by the Maryland Department of Human Services for the allegation of neglect. Through a review of the case record, it was learned SM allowed SC, age 11, to supervise SS, then age 3, while they played outside in the front yard and SM was inside the home. SC was not capable of providing adequate care and supervision for SS due to SC's developmental delays. The determination of the allegation was not documented in the record. The case closed 8/21/17 with no further child welfare services needed.

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: 01/24/2018

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

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? There was no FASP completed as the case was coded improperly as an Out of Town Inquiry.				
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: An agency provided Preventive Services, although it was unknown what agency as it was not documented in the record.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Assessment of Services and Maintaining Records
Summary:	OCDSS documented in Connections this was an Out of Town Inquiry, which was not accurate.
Legal Reference:	18 NYCRR 428.1(a)(2) and 428.3(a)
Action:	This practice has been discontinued and a corrective action is already in place.

Preventive Services History

A referral was received by OCDSS for Preventive Services for SM and her CHN on 1/24/18 as the family had recently moved to Orange County from Maryland. The family needed assistance with obtaining services for SC's developmental disabilities, school placement for SC, and obtaining housing, employment, and public assistance. OCDSS documented in Connections the case was an Out of Town Inquiry, which was not accurate. OCDSS began coordinating SC's school

placement and services for his developmental disabilities. OCDSS referred SM for DV services and MH counseling and provided SM with a housing list. SC passed away on 3/3/18 and an SCR report was received. The case was closed on 3/5/18 with the family's service needs being re-evaluated in the open CPS investigation.

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