Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-030

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

Issue Date: Dec 08, 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 had an open investigation or a CPS monitored services 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		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Dutchess
Gender: Male
Date of Death: 06/22/2023
Initial Date OCFS Notified: 06/22/2023

Presenting Information

The SCR report alleged on 06/22/2022, the grandmother cared for the subject child and sibling. She put the sibling on the bus while the subject child played in the front yard. The grandmother tried to get the child inside and when he refused, went inside to get candy, and left him unsupervised in the yard for a couple of seconds. She came back out, and the child was still in the front yard but ran to the side of the home. She attempted to follow the child but was unable and when she caught up, could not see him. The grandmother called the father at work, who returned home, and went to the side of the home near the septic tank and saw the plastic lid of the tank ajar. The father took the lid off, found the child inside, and got him out. The mother, father, grandfather, and grandmother did not ensure the lid, which moved easily, was safely secured/locked. The father performed CPR and 911 was called. EMS continued CPR, and the child was transported to the hospital and pronounced deceased.

Executive Summary

This fatality report concerns the death of the 2-year-old male subject child that occurred on 6/22/23. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, Lack of Supervision, and Inadequate Food, Clothing, and Shelter against the mother, father, maternal grandmother, and maternal grandfather. At the time of his death, the subject child resided with his mother, father, maternal grandparents, and two siblings, ages 6 and 4 years old.

Dutchess County Department of Community and Family Services (DCDCFS) completed casework and collateral contacts and learned that on 6/22/23, the 6-year-old sibling and subject child were in the care of the maternal grandmother. Around 8:00AM, the grandmother got the 6-year-old sibling on the school bus, while the subject child played in the front yard of the home. After the bus left, the grandmother attempted to get the subject child to come inside the home, but he refused and ran around the side of the house. The grandmother attempted to follow the subject child, but when she got to the side of the house, she did not see the subject child and was unable to locate him. The grandmother called the maternal grandfather and father at work and informed them she was unable to locate the subject child. The father returned home and immediately went to where the septic tank was located, noticing the plastic lid was ajar. The father removed the lid and located the subject child in the tank. The father retrieved the subject child and began CPR while the grandmother called 911. Law enforcement and emergency medical services responded and continued life-saving efforts. The subject child was transported to the hospital, where he was pronounced deceased at 9:21AM.

An autopsy was performed, and the final cause was listed as asphyxia due to drowning and the manner of death was accident. There was a criminal investigation related to the subject child's death and law enforcement did report the family members' knowledge of the condition of the septic lid was negligent; however, no charges were filed as it was determined there was no criminality regarding the death.

Bereavement services were offered to the family. The 6-year-old sibling was actively engaged in counseling, and the mother was working to also engage the 4-year-old sibling in counseling. A preventive services case was opened to ensure the family became engaged in grief counseling and to monitor the ongoing concern regarding the condition of the home.

While the CPS investigation was correctly indicated regarding the allegation of Inadequate Food, Clothing, and Shelter due to the condition of the home being a safety hazard for the children; the allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the mother, father, grandmother, and grandfather were inappropriately substantiated regarding the subject child. The record did not reflect a fair preponderance of evidence to support the

allegations. The mother, father, and grandfather were not home at the time of the incident. The grandmother, who was caring for the subject child at the time of his death, reported being unaware that the lid to the septic tank did not lock. The record did not support that the grandmother was an inappropriate caretaker for the children. Despite the grandmother's many medical diagnoses and possible limitations, there was no indication the grandmother was an inadequate caregiver for the children or that there had been concerns in the past regarding her ability to care for them. The grandmother's medical providers did not provide any insight regarding the grandmother's ability to care for young children. The CPS investigation was closed on 8/21/23, while the services case remained open.

PIP Requirement

This review resulted in a citation related to casework practice. In response, DCDCFS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the DCDCFS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, DCDCFS will review the plan(s) and revise as needed.

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 investigation was correctly indicated; however, not all allegations were determined appropriately, including DOA/Fatality, IG and LS.

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.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The allegations of DOA/Fatality, IG, and LS against the mother, father, grandmother, and grandfather were inappropriately determined, as the record did not reflect a fair preponderance of evidence to support the allegations.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	DCDCFS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Westchester Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/22/2023 **Time of Death:** 09:21 AM

Time of fatal incident, if different than time of death: 08:05 AM

County where fatality incident occurred: Dutchess
Was 911 or local emergency number called? Yes
Time of Call: 08:18 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested 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	Male	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	42 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	61 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	60 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Year(s)

Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)

LDSS Response

Upon receipt of the SCR report, DCDCFS coordinated their investigation with LE, interviewed the subjects of the report, assessed the safety of the SSs, contacted collateral sources, and offered fatality-related services.

DCDCFS interviewed the SM, SF, MGM, and MGF and learned on the morning of 6/22/23, the SF left for work around 5:45AM and the MGF left sometime after, with the SM, MGM, SC, and 6yo SS still at home. The 4yo SS was at the home of the PGM. The SM awoke around 6:00AM, fed and changed the SC, gave him cough medicine, and got the 6yo SS ready for school. The SM left for work around 7:40AM, and the SC and 6yo SS stayed with the MGM. The MGM had an alarm set for 7:56AM to get the 6yo SS ready to get on the school bus. The MGM went outside and sat on the front steps waiting for the bus to arrive while the SC played in the front yard, approximately 40 feet from the MGM. After the 6yo SS got on the bus and left for school, the MGM called the SC to come inside. The SC refused and the MGM got a piece of candy from inside the home. The MGM offered the SC the candy, but he still refused and ran around the side of the home. The MGM reported the SC usually came right to her. The MGM followed the SC around the side of the home, but when she got around the corner, she did not see the SC. The MGM called the SC's name and looked around but was unable to locate the SC. The MGM noted a gap in the septic tank lid but stated she did not hear splashing or any noise, and therefore did not suspect the SC was in the tank. The MGM called the SF and MGF at work around 8:05AM and informed them she was unable to find the SC. The MGF and SF arrived at the home within 10 minutes. The MGF went to one side of the home, while the SF went to the other side where the septic tank was located. The SF observed the plastic lid to be ajar, removed the lid, and observed the SC face-down with his arms extended above his head. The SF removed the SC from the septic tank, began CPR, and called the SM to tell her to come home. The MGM called 911, and LE and EMS responded. Life-saving measures were continued, the SC was brought to the hospital, and he was pronounced deceased.

During interviews with the SM and MGM, they stated they were aware the septic tank had been serviced, but they were unaware of any condition of the lid. The MGF and SF stated they were made aware the lid was not locking properly by the septic company. However, when DCDCFS contacted the septic company and requested they come to the residence to assess the tank and lid for any repairs, the company stated the lid was the correct lid and no repairs were necessary. The family screwed the lid down and built a wooden structure to cover the lid of the tank, as well as a fence in the backyard to block a large embankment. All adults denied the children ever played near this area of the home before, and they were not allowed in the backyard.

DCDCFS made thorough efforts to contact all necessary collaterals including the MGM's doctor and was made aware of numerous medical diagnoses; however, the SM reported she was only aware the MGM had a defibrillator and was unaware of any other diagnoses, stating the MGM had "always been this way." The record did not reflect prior concern regarding the MGM's ability to care for the children or that medical personnel provided input regarding the MGM's ability to care for young children.

The investigation revealed concern regarding the condition of the home being overly cluttered. DCDCFS worked diligently with local businesses to assist the family in obtaining a dumpster to clean the home and opened a services case to monitor the progress and assist with grief services. The SSs were assessed to be safe in the care of the parents. The SF did report the parents would not be utilizing the MGM as a caretaker for the SSs due to DCDCFS' concerns.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: Dutchess County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065291 - Deceased Child, Male, 2 Yrs	065292 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065295 - Grandparent, Female, 60 Year(s)	Lack of Supervision	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065295 - Grandparent, Female, 60 Year(s)	Inadequate Guardianship	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065295 - Grandparent, Female, 60 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065295 - Grandparent, Female, 60 Year(s)	DOA / Fatality	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065294 - Grandparent, Male, 61 Year(s)	Inadequate Guardianship	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065294 - Grandparent, Male, 61 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065294 - Grandparent, Male, 61 Year(s)	DOA / Fatality	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065294 - Grandparent, Male, 61 Year(s)	Lack of Supervision	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065293 - Father, Male, 42 Year(s)	Inadequate Guardianship	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065293 - Father, Male, 42 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065293 - Father, Male, 42 Year(s)	DOA / Fatality	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065292 - Mother, Female, 32 Year(s)	Lack of Supervision	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065292 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065292 - Mother, Female, 32 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065291 - Deceased Child, Male, 2 Yrs	065293 - Father, Male, 42 Year(s)	Lack of Supervision	Substantiated
065296 - Sibling, Female, 6 Year(s)	065295 - Grandparent, Female, 60 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated

065296 - Sibling, Female, 6 Year(s)	065292 - Mother, Female, 32 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065296 - Sibling, Female, 6 Year(s)	065293 - Father, Male, 42 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065296 - Sibling, Female, 6 Year(s)	065294 - Grandparent, Male, 61 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065297 - Sibling, Female, 4 Year(s)	065292 - Mother, Female, 32 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065297 - Sibling, Female, 4 Year(s)	065293 - Father, Male, 42 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065297 - Sibling, Female, 4 Year(s)	065294 - Grandparent, Male, 61 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
065297 - Sibling, Female, 4 Year(s)	065295 - Grandparent, Female, 60 Year(s)	Inadequate Food / Clothing / Shelter	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?	☒	☐	☐	☐
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:
DCDCFS opened a services case to monitor the family's progress in cleaning out the home to declutter the space and assist the family in becoming engaged with grief counseling.

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
The SSs stayed with a relative while safety concerns were rectified. No removal of the SSs was necessary.

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:
DCDCFS offered bereavement services and assisted with funeral arrangements for the SC. DCDCFS reached out to local businesses to provide the family with a dumpster to assist in cleaning out the family's home, due to generational clutter. DCDCFS opened a services case to monitor the clean-up, help the family get engaged in counseling, and provide ongoing support following the SC's death.

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:
Bereavement services were offered on behalf of the SSs. The 6yo SS was engaged with therapy and had a session immediately after the fatality, due to her emotional response to the SC's death. The 6yo's therapist reported the family engaged in sessions also, and the SM was actively working to get the 4yo SS engaged as well.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to all family members. The MGM was distressed over the death of the SC and DCDCFS opened a services case with a goal to assist the family, including the MGM, in engaging in grief counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? No

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 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.

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