Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-038

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

Issue Date: Dec 22, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 14 day(s)
Jurisdiction: Orange
Gender: Male
Date of Death: 07/18/2023
Initial Date OCFS Notified: 07/18/2023

Presenting Information

An SCR report was received on 7/18/23 and alleged that on the same day, the mother was sleeping in the same bed as the 14-day-old male subject child. The mother woke up and noticed the child was unresponsive. Somebody in the home called 911 and emergency medical services responded. Cardiopulmonary resuscitation was administered and the child was transported to the hospital where he was pronounced deceased at 3:37 AM. It was believed that the unsafe sleep environment contributed to the death.

Executive Summary

This fatality report is regarding the death of a 14-day-old male child that occurred on 7/18/23. An SCR report was received on the same day and alleged DOA/Fatality and Inadequate Guardianship against the mother. The child resided with the mother, grandmother, maternal aunt, 1-year-old cousin, and an unrelated home member. The 1-year-old cousin was assessed to be safe in the care of the maternal aunt. The father of the child was identified by the mother; however, he denied paternity and reported he had no contact with the child.

The Orange County Department of Social Services (OCDSS) coordinated investigative efforts with law enforcement. It was learned that on 7/17/23, the mother left the home at 9:30 PM to spend time with a friend. The child was left in the care of the maternal grandmother. The mother and friend smoked marijuana, and the mother returned home around 11:00 PM. The mother laid down on the sofa with the child nestled into her arm. The mother woke up around 2:30 AM on 7/18/23 and noticed the child was unresponsive. The mother alerted the grandmother, who began cardiopulmonary resuscitation while the mother called 911. First responders arrived and transported the child to the hospital where life-saving measures were continued. The efforts to revive the child were unsuccessful and he was pronounced deceased at 3:37 AM.

An autopsy was performed and the final results were not yet available at the time the CPS investigation was closed. The preliminary cause of death was listed as undetermined with unsafe sleep conditions. OCDSS was provided a copy of the final autopsy once it was completed and documented the information in the investigation conclusion narrative via closed case maintenance. The cause of death was undetermined (sleeping on the couch with mother) and the manner was undetermined. Law enforcement's investigation did not reveal any criminality regarding the child's death and their case was closed.

Due to the mother's marijuana use before she slept with the subject child, OCDSS added and substantiated the allegation Parent's Drug/Alcohol Misuse against the mother. Inadequate Guardianship was substantiated against the mother, as OCDSS determined she failed to meet a reasonable standard of care for the child when she co-slept with him on the couch. DOA/Fatality was unsubstantiated, as OCDSS determined there was insufficient evidence to associate the unsafe sleep environment with the death.

OCDSS provided fatality-related services to the family. The mother was previously engaged in grief and mental health counseling due to the death of her other child in 2022. That death was investigated by CPS and ruled to be a homicide by the mother's then boyfriend. A fatality report was written regarding that death. After the completion of all required casework activity, the CPS investigation was indicated and closed on 9/15/23.

PIP Requirement

OCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The safety of the surviving cousin was assessed throughout the investigation.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
Although all required casework activity was completed, the Risk Assessment Profile did not reflect information that was consistent with the determination of the DOA/Fatality allegation.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The elevated risk element section within the RAP indicated that the child's death was a result of abuse or maltreatment by a caretaker; however, this was inconsistent with the unsubstantiated DOA/Fatality allegation.
Legal Reference:	18 NYCRR 432.2(d)
Action:	OCDSS will consider all risk elements identified throughout the course of the investigation and

	accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/18/2023 **Time of Death:** 03:37 AM

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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	Aunt/Uncle	No Role	Female	25 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	14 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	57 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	1 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	24 Year(s)

LDSS Response

Upon receipt of the SCR report on 7/18/23, OCDSS coordinated efforts with law enforcement, sent notification to the Medical Examiner and district attorney's office, interviewed the family, gathered information from medical collaterals, and provided fatality-related services.

OCDSS interviewed the mother at her home regarding the incident. On the evening of 7/17/23, the mother left the home to go spend time with a friend. The child remained home in the care of the maternal grandmother. The mother and her friend

smoked marijuana. The friend dropped the mother back home around 11:00 PM. The mother laid down on the couch with a pillow behind her head. The child was nestled in the mother's arm adjacent to the back of the couch. On 7/18/23 around 2:30 AM, the mother woke up and the child was in the same position but was not breathing. The mother denied she rolled onto the child. The mother picked the child up and brought him into the maternal grandmother's room. The maternal grandmother began CPR and the mother contacted 911.

The maternal grandmother was interviewed and confirmed the mother left the child in her care while she went to spend time with a friend. The maternal grandmother stated the child was in her bedroom with her sleeping on the bed. There were no concerns for the child during that time. The mother returned home, retrieved the child from the maternal grandmother, fed him a bottle, and then went to sleep in the living room. When asked about the child's sleep environment, the maternal grandmother reported it was typical for the mother and child to sleep in the living room. The mother reported that she had a crib for the child, but sometimes he would fuss so she would co-sleep with him.

OCDSS interviewed relevant home members and relatives. The maternal aunt reported she was at work at the time of the fatality. She saw the child before leaving and had no concerns for him. The unrelated home member reported she was sleeping on the futon in the same room as the mother and child when she was woken by the mother in distress. The mother identified the father of the child; however, he denied paternity and reported he had never met the child. Though not able to be interviewed due to his age, the cousin was observed during multiple home visits and was assessed to be safe in the aunt's care. The family was educated on safe sleep guidance and OCDSS observed a safe sleep environment for the cousin.

The subject child was last seen by the pediatrician on 7/7/23 and there were no medical concerns noted. The cousin's pediatrician and daycare provider reported no concerns for the cousin's care. Throughout the investigation, OCDSS documented and monitored a safety plan regarding the need for a sober caretaker for the cousin due to concerns about marijuana use in the home. The family agreed that there would always be a sober caretaker for the cousin. During a home visit, OCDSS observed the mother's bottles of medication on the couch. OCDSS discussed the need for all medication to be out of reach of children.

Once all casework objectives were completed OCDSS indicated and closed their CPS investigation on 9/15/23.

Official Manner and Cause of Death

Official Manner: Undetermined
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 referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065468 - Deceased Child, Male, 14 Days	065469 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
065468 - Deceased Child, Male, 14 Days	065469 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated

065468 - Deceased Child, Male, 14 Days	065469 - Mother, Female, 24 Year(s)	Parents Drug / Alcohol Misuse	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:

OCDSS documented diligent efforts to interview the biological fathers of the children face-to-face; however, the fathers were interviewed via phone call.

Fatality Safety Assessment Activities

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

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

adequate?				

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The RAP was completed on 9/14/23 and indicated that the child's death was due to abuse or maltreatment by a caretaker. This was not consistent with the unsubstantiated allegation of DOA/Fatality against the mother.

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The SM was referred for a substance use assessment due to daily marijuana use. The SM was recommended for treatment and declined. The SM was already enrolled in mental health services due to the death of her other child. The family was referred to domestic violence and mental health services. The family accepted assistance with the funeral arrangements.

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

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/02/2022	Other Deceased Child - Deceased sibling, Male, 3 Years	Mother, Female, 23 Years	DOA / Fatality	Unsubstantiated	No
	Other Deceased Child - Deceased sibling, Male, 3 Years	Mother's Partner, Male, 23 Years	DOA / Fatality	Substantiated	
	Other Deceased Child - Deceased sibling, Male, 3 Years	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Substantiated	
	Other Deceased Child - Deceased sibling, Male, 3 Years	Mother's Partner, Male, 23 Years	Internal Injuries	Substantiated	
	Other Deceased Child - Deceased sibling, Male, 3 Years	Mother's Partner, Male, 23 Years	Lack of Medical Care	Substantiated	
	Other Deceased Child - Deceased sibling, Male, 3 Years	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated	

Report Summary:
OCDSS received an SCR report regarding the deceased sibling. The mother went to work on the morning of 6/2/22 at 6:00 AM. Before leaving the residence, the mother transferred the sibling from his toddler bed in her bedroom to another toddler bed in the living room. The sibling was asleep at the time and the mother's boyfriend was asleep on the couch in the living room. At approximately 7:57 AM, the mother's boyfriend called the mother and told her the sibling was having a seizure. The mother instructed the boyfriend to call 911, which he did. EMS arrived, began life-saving efforts, and transported the sibling to the hospital where he was pronounced deceased at 9:10 AM.

Report Determination: Indicated **Date of Determination:** 02/28/2023

Basis for Determination:
OCDSS substantiated the allegations against the mother's partner. It was determined the sibling's death was due to blunt force trauma to the head and torso and the mother's partner was charged with homicide. IG against the mother was substantiated, as she allowed her partner to be the sole caretaker of the sibling, despite a safety plan implemented on 4/26/22, which did not allow for such due to the sibling obtaining a broken arm while in the mother's partner's care. DOA/Fatality against the mother was unsubstantiated because it was determined her partner caused the sibling's death.

OCFS Review Results:
OCDSS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, daycare providers, and relatives. OCDSS provided fatality-related services to the parents upon receipt of the fatality report. The allegations were appropriately determined given the information gathered. OCDSS determined they would not file a family court petition, as there were no siblings, and there were pending criminal court proceedings regarding the death. The investigation was indicated and closed on 2/28/23.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/26/2022	Other Deceased Child - Deceased sibling, Male, 3 Years	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Substantiated	No
	Other Deceased Child - Deceased sibling, Male, 3 Years	Mother's Partner, Male, 23 Years	Lack of Supervision	Substantiated	
	Other Deceased Child - Deceased sibling, Male, 3 Years	Grandparent, Male, 54 Years	Fractures	Unsubstantiated	
	Other Deceased Child - Deceased	Grandparent, Male,	Inadequate	Unsubstantiated	

sibling, Male, 3 Years	54 Years	Guardianship	
Other Deceased Child - Deceased sibling, Male, 3 Years	Grandparent, Male, 54 Years	Lacerations / Bruises / Welts	Unsubstantiated
Other Deceased Child - Deceased sibling, Male, 3 Years	Grandparent, Male, 54 Years	Swelling / Dislocations / Sprains	Unsubstantiated

Report Summary:
OCDSS received a report from the SCR which alleged that on 4/26/22, the subject child sustained a supracondylar fracture of his right distal humerus, swelling to the right elbow, and a bruise on his right cheek, while in the care of the maternal grandfather. No explanation was provided for the injuries.

Report Determination: Indicated | **Date of Determination:** 06/17/2022

Basis for Determination:
OCDSS substantiated the allegations of Lack of Supervision and Inadequate Guardianship against the mother's boyfriend regarding the subject child as the record reflected the boyfriend fell asleep while caring for the subject child and the child sustained a broken arm during the period the boyfriend was asleep. OCDSS unsubstantiated allegations of Inadequate Guardianship, Swelling/Dislocation/Sprains, Fractures, and Lacerations/Bruises/Welts against the grandfather as he was not present at the time the child sustained the injuries and the investigation revealed the mother's boyfriend was with the child.

OCFS Review Results:
OCDSS spoke with relevant collateral sources and completed a thorough investigation into the allegations. The child died during the investigation and a fatality report was registered. OCDSS delivered NOEs late and documented it was due to transferring the case for MDT response.

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

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

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

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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.

Additional Local District Comments

Orange County disagrees that choosing the elevated risk factor was incorrect. Although there was not a fair preponderance of evidence to prove actions of the caretaker caused the child's death, there is high suspicion that unsafe sleep, while under the influence, was the main factor. The RAP is a tool to predict future risk and there is elevated future risk regarding this caretaker.

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