Report Identification Number: SV-23-052

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

Issue Date: Feb 12, 2024

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 | **Jurisdiction:** Suffolk | **Date of Death:** 08/26/2023
Age: 2 month(s) | **Gender:** Male | **Initial Date OCFS Notified:** 08/26/2023

Presenting Information

An SCR report alleged that on 08/25/23 around 11:00pm, the mother put the 2-month-old subject child face up in his bassinet to sleep. On 8/26/23, at about 8:25am the mother found the child face down and unresponsive. The mother called 911 and began resuscitative measures as instructed by the 911 operator. First responders arrived and took over resuscitative measures. The child was transported to the hospital. Hospital staff continued to perform life-saving measures upon the child's arrival. At 9:29am, the child was pronounced deceased. The child was an otherwise healthy child, and the mother and the father did not have an explanation for the child's death. The father was present outside of the home when police arrived. It was unknown what actions the father took during that time. In addition, the father was a registered child sex offender residing in the home with the surviving 3-year-old twin siblings. The mother was aware of the father's sex offender status but allowed him to reside in the home with the children.

Executive Summary

This report concerns the death of the 2-month-old male subject child. Suffolk County Department of Social Services (SCDSS) received an SCR report regarding the child's death on 8/26/23. At the time of the child's death, he resided with his mother and 3-year-old twin siblings. The 13-year-old sibling resided with the maternal grandparents under an informal plan made by the mother and had regular contact with the mother, child, and twin siblings. The mother often stayed with the child and twin siblings at the maternal grandparents' home. The child's father resided in a separate home; however, the father spent time at the mother's home to assist the mother with the care of the child. The father had an 11-year-old child that he had no contact with. Following the death, SCDSS assessed the 11-year-old child as safe with his biological mother. SCDSS assessed the 13-year-old sibling and the twin siblings to be safe with the mother and made a safety plan the mother would not allow the father around the children.

The night preceding the death, the father stayed at the home with the mother, subject child, and twin siblings. SCDSS interviewed the parents separately and learned the night prior to the child's death the child was very fussy. The mother fed the child a bottle of formula with cereal in it and shortly after placed him to sleep on his back, in the bassinet at about 11:00pm. The parents reported the child normally woke up every 3 or 4 hours for a feeding; however, that night the child did not wake up at all, and the parents slept through the night. The mother woke up around 8:00am, and checked on the child in the bassinet, which was located next to her bed. The mother observed the child face down on his stomach in the corner of the bassinet. The mother picked the child up to turn him back onto his back, and the child was cold, not breathing, and unresponsive. The mother woke the father, and he told her to call 911. The mother called 911 while the father went outside to wait for first responders. The mother began resuscitative measures on the child as instructed by the 911 operator until law enforcement arrived. Law enforcement arrived at the home and took over resuscitative measures. Law enforcement initiated the transport of the child to the hospital and met the ambulance in the community while en route. The child was placed in the ambulance, EMS took over resuscitative measures and transported the child to the hospital. Hospital staff took over life-saving measures; however, were unsuccessful and the child was pronounced deceased at 9:29am.

An autopsy was performed; however, the record did not reflect the final autopsy results were available at the time this report was written. The medical examiner found no signs of trauma to the child's body. Law enforcement found no criminality regarding the death and no arrests were made. The criminal investigation remained open pending the final autopsy results. The father was criminally charged for providing law enforcement with a false name. Due to the father being on probation at the time, a violation was filed against the father for being around children and police contact. The

outcome of those charges were unknown at the time this report was written.

SCDSS offered the mother bereavement services for the family, and she declined. The 13-year-old sibling engaged in counseling at school after the death of the child, and the mother stated she was engaged in private counseling. The mother declined a need for counseling for the 3-year-old twin siblings and they continued to be engaged with Early Intervention services. The record did not reflect the mother was offered burial assistance. SCDSS inaccurately completed the 7-day safety assessment. SCDSS did not gather enough information to make an appropriate determination regarding the allegation of Inadequate Guardianship against the mother regarding the twin siblings. The allegation of Inadequate Guardianship should have been added against the father regarding the twin siblings due to his sex offender status and conditions.

PIP Requirement

SCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS 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?** — No

Explain:

Casework activity was not commensurate with the casework circumstances. The record did not reflect that SCDSS explored the mother's knowledge regarding the conditions of the father's probation nor was there a discussion about the inconsistencies the mother relayed to LE about the father being in the home at the time of the fatal incident. The father was aware the conditions of his probation prohibiting him from being around children, however; he continued to frequent the mother's home, which placed the two non-verbal developmentally disabled siblings at imminent risk of harm.

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:
Casework activity was not commensurate with the case circumstances, the 7-Day Safety Assessment was completed inaccurately and the allegation of IG was inappropriately determined. Allegations of IG should have been added against the father regarding the twin siblings.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The record reflected SCDSS made a safety plan with the mother regarding the surviving siblings due to the father's sex-offender status and conditions of his probation prohibiting his contact with minors. The 3yo twin siblings were non-verbal and developmentally disabled. The safety plan was not reflected in the 7-Day Safety Assessment and the assessment documented there were no safety factors.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.
Issue:	Appropriateness of allegation determination
Summary:	SCDSS should have added allegations of IG against the father regarding the 3yo twin SSs. The record reflected the father was aware he was not supposed to be around any minor children including his own, based on his sex offender conditions and admitted to being in the home with the SC and twin siblings. The twin siblings were non-verbal, and both had a diagnosed developmental disability; therefore, the father being in the home placed the twin SSs at imminent risk of harm. The father provided a false name to LE and was subsequently charged for violating the conditions of his probation.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	SCDSS 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.
Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	SCDSS unsubstantiated the allegation of IG against the mother regarding the 3yo twin siblings stating the mother was unaware of the father's sex offender status; however, the record did not reflect SCDSS fully explored with the mother what she knew about the father being on probation or why she reported to law enforcement the father was not in the home at the time of the fatal incident.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	SCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/26/2023 **Time of Death:** 09:29 AM

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

County where fatality incident occurred: Suffolk
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:

- [x] 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 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	40 Year(s)
Other Household 2	Sibling	No Role	Male	13 Year(s)
Other Household 3	Other Adult - Mother of 11yo other child	No Role	Female	35 Year(s)
Other Household 3	Other Child - Father's child	No Role	Male	11 Year(s)
Other Household 4	Other Adult - Father of the 13yo SS	No Role	Male	36 Year(s)

LDSS Response

Within the first 24-hours of the investigation, SCDSS contacted the source of the report, and notified the medical examiner, LE, and the district attorney’s office of the death. Throughout the investigation, SCDSS completed interviews with the parents, relatives, first responders, hospital staff, and the pediatrician.

SCDSS interviewed the mother and learned that in the weeks preceding the SC's death, the SC had acid reflux. The mother told SCDSS the pediatrician directed her to put cereal, specifically cheerios, crushed up and into the formula. The mother said she was adding the cereal to the formula, and it seemed to be helping. The SC normally went to bed between 8:00 and 9:00pm; however, the night prior to the SC’s death he was fussy and went to bed at about 11:00pm. The SC usually woke up every 3 or 4 hours during the night but the night of the fatal incident he did not wake up at all, and the mother figured

he was tired from having gone to sleep later. The mother woke up at about 8:00am and found the SC unresponsive. The mother woke up the father and then called 911. The mother performed CPR on the SC until first responders arrived. The mother reported the father of the SC was not the father of the twin SSs and she declined to provide SCDSS with the father's name of the twin siblings. SCDSS checked the putative father's registry and was unable to identify the father of the twin siblings.

SCDSS met with the father and learned the night prior to the death the father admitted he stayed at the mother's residence and helped put the SC to bed. The father said he frequently stayed at the mother's home, and they would take turns giving the SC a bottle during nighttime feedings. The night of the death the father reported he and the mother both fell asleep, and the SC did not wake up for a feeding. The father was unsure of the time the mother woke him and told him the SC was not breathing. The father told the mother to call 911 and he went outside to wait for EMS to arrive. LE arrived at the home and went to the mother's apartment.

SCDSS learned the father was a level 2 registered sex offender, on probation, and was not allowed to be around any minors, including his own children. The father reported he frequented the mother's home to help the mother care for the children. The day of the fatal incident the father initially gave LE a fake name because he knew it was a violation of his probation to be at the home with the children due to his sex offender status, and he was arrested and charged with false impersonation.

SCDSS met with the 13-year-old and 3-year-old twin siblings at the mother's home. SCDSS attempted to interview the 3-year-old twin siblings; however, they were unable to be interviewed based on their developmental disability and were non-verbal. The 13-year-old sibling said he saw the child at the maternal grandparents home the day prior to the death. He noticed that the child was breathing different and that he observed the child roll over on his side when the grandmother changed the child's diaper. The 13-year-old sibling said the child was unable to roll back over, and the grandmother had to roll the child on his back. The 11yo child was seen and interviewed with his mother, and he had no contact or visitation with the father.

SCDSS contacted numerous collateral contacts including law enforcement, probation, the pediatrician, school staff, EMS and hospital staff. SCDSS spoke with the father's probation officer and learned the father was on probation and as part of the father's sex offender conditions he was not permitted to have any contact at all with any minors, including his own biological children. The pediatrician had no concerns for the mother's care of the children. On 7/24/23, the SC was seen, and the mother reported the SC had congestion and mucus in his nose. The pediatrician attributed the mucus to reflux and suggested repositioning the SC during feedings and adding cereal to the SC's bottle. The record was unclear as to what type of cereal the pediatrician advised the mother to give the child. The 13yo SS and the mother were engaged with counseling services after the SC's death and the mother declined services for the twin SSs.

At the close of the investigation the siblings were deemed safe with the mother. The father did not reside in the home; however, the record was unclear on the status of the father's criminal charges unrelated to the death. At the close of the investigation no criminal charges were filed against the parents regarding the death and the criminal investigation remained open pending the final autopsy report. SCDSS unfounded case and the investigation was closed on 10/20/23.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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: Suffolk 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
066212 - Deceased Child, Male, 2 Month(s)	066213 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
066212 - Deceased Child, Male, 2 Month(s)	066213 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
066212 - Deceased Child, Male, 2 Month(s)	066216 - Father, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
066212 - Deceased Child, Male, 2 Month(s)	066216 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
066214 - Sibling, Female, 3 Year(s)	066213 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
066215 - Sibling, Female, 3 Year(s)	066213 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated

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:
SCDSS offered the family bereavement services and they declined. The 13yo SS and the mother were engaged in counseling services and the 3yo twin siblings remained engaged with Early Intervention 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 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 family declined bereavement services, the mother and 13yo SS independently engaged in counseling services after the death. The 3yo twin siblings continued to engage with Early Intervention services after the death. The record did not reflect the mohter was offered burial assistance.

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? No
Explain:
The 13yo SS engaged with counseling services at school after the death. SCDSS offered the mother services on behalf of the 3yo twin siblings, and she declined. The two siblings remained engaged with Early Intervention services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
SCDSS offered the father counseling services and he declined. SCDSS offered the mother bereavement services, and she

declined. The mother reported prior to the case closure she was engaged in counseling services.

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

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 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.

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