Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-17-034

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

Issue Date: Jan 19, 2018 **(Report was reissued on: Jan 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: 10 month(s)
Jurisdiction: Herkimer
Gender: Male
Date of Death: 07/22/2017
Initial Date OCFS Notified: 07/23/2017

Presenting Information

An SCR report was received which alleged on 7/22/17, the parent substitute (PS) found the 10-month-old SC unresponsive in his Pack and Play at approximately 9:12AM. Emergency services were contacted, and resuscitation efforts were unsuccessful. SC was pronounced dead at 10:22AM. The last time SC was observed alive was at 5AM, by PS. SC was an otherwise healthy child, and the cause of death was unknown.

Executive Summary

This fatality report concerns the death of a 10-month-old male (SC) that occurred on 7/22/17. A report was made to the SCR on this same date, with allegations of IG and DOA/Fatality against SM and her boyfriend (PS) regarding SC. Herkimer County Department of Social Services (HCDSS) conducted a thorough investigation surrounding SC's death. The final autopsy report was not available for review at the time of this writing, and the cause and manner of death had not yet been determined.

SC was a healthy child with no underlying medical concerns, and was up to date with immunizations. SC was prescribed a soft helmet to wear 23 hours a day to aid in reshaping the back of his head, which was flat. It was noted this did not contribute to his death in any way, and the neurologist had no concerns regarding SC or his care. SC had resided with SM, PS, and his 5-year-old SS. SC's biological father (BF1) resided in North Carolina, and had last seen SC in May 2017. SS had regular visitation with his biological father (BF2), who resided in a nearby town. On the date of SC's death, SS had been on visitation with BF2 and was not present for any of the events.

It was discovered on the night of 7/21/17, SM put SC to bed in his Pack and Play at approximately 7:30PM; it was not documented how SC was placed in the Pack and Play. SM checked on SC around 3AM, and he appeared fine. PS awoke around 5AM to check on SC and he felt warm to the touch. PS removed SC's arms from the swaddle and gave SC a bottle of ice water. PS then left the room and went back to bed. At approximately 9AM, PS awoke and again went to check on SC. At that time, he found SC lying on his back, unresponsive. PS's cousin (OA) was visiting the home and had stayed the night. PS woke OA, who had been sleeping on a couch in the nearby living room, and OA called 911. EMS arrived at the scene and transported SC to the hospital, where he was pronounced deceased.

LE reported there was a blanket, a sweatshirt, and a stuffed toy found in the Pack and Play when they arrived, but HCDSS did not document a discussion surrounding safe sleep or normal sleep practices with the caregivers regarding SC at any point in the investigation. The record did not reflect that HCDSS interviewed OA, or conduct a CPS history check for North Carolina, where it was noted SM and the CHN previously resided. The 24-Hour Safety Assessment was completed timely in CONNECTIONS; however, it did not speak to the safety of the SS, only the circumstances surrounding SC's death, and a question in the Risk Assessment Profile was answered incorrectly.

From the time the investigation began to the time of this writing, HCDSS met with and interviewed SM, PS, BF2 and the SS, as well as spoke with BF1 and other family members. Further, HCDSS followed up with numerous collateral contacts, assessed home environments, and referred family members to grief and trauma services. There were no criminal charges pursued against any of the caregivers, and HCDSS found no evidence to support the allegations in the report. HCDSS appropriately unfounded and closed the investigation.

PIP Requirement

Review of this investigation resulted in several citations related to casework practices. In response, HCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) HCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, HCDSS will review the plan(s) and revise as needed to further address on-going 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:
Sufficient information was gathered to assess the safety of the SS at the conclusion of the investigation. The decision to unfound and close the case was appropriate.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
The casework was commensurate with the case circumstances. HCDSS gathered sufficient information to determine the case and close.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	OA was present when SC was found unresponsive. HCDSS made no attempts to interview OA, or establish him as a possible person legally responsible. HCDSS did not request CPS records from North Carolina, where SM and the CHN previously resided.

Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	HCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	Although the 24 Hour Assessment was completed timely in Connections, it did not speak to the safety of the SS; only the circumstances surrounding SC's death.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	Within 24 hours of receiving a report, the child protective service must provide information about whether the surviving child(ren) may be in immediate danger of serious harm and document such accordingly in the Initial Safety Assessment.
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	The record did not reflect whether HCDSS explored if SM and PS had been educated surrounding safe sleep or if they were regularly practicing such with SC. HCDSS did not gather details as to how SC was placed to sleep and with what objects on his DOD.
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	HCDSS will complete investigations thoroughly and adequately by gathering details and fully exploring all factors that may have contributed to the abuse or neglect of a child.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/22/2017 **Time of Death:** 10:22 AM

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

County where fatality incident occurred: Herkimer
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 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? 4 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
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	10 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Other Household 1	Father	No Role	Male	27 Year(s)
Other Household 2	Other Adult - BF of SS	No Role	Male	26 Year(s)

LDSS Response

On 7/22/2017, HCDSS received a report regarding the death of SC. HCDSS initiated their investigation within 24 hours, and coordinated their efforts with LE. HCDSS contacted the source of the report, reviewed CPS history in NYS, and determined there was a SS who resided in SC's home. HCDSS found PS also had a child of his own who resided with his biological mother. HCDSS received copies of statements made by PS and OA to LE.

On 7/23/17, HCDSS and LE completed a home visit and conducted initial interviews with SM and PS. There were no concerns noted regarding the home environment. Through interviews, it was learned SS had been with his biological father (BF1) during the time of the incident, and was not witness to any of the events. It was further discovered SC's biological father (BF2) lived in North Carolina and the last time he saw his son was May 2017; HCDSS notified both BFs of the investigation.

SM and PS reported SC was not ill prior to his passing, nor did he have any medical conditions. SC was up to date on his immunizations and pediatrician visits. SC was teething, and wore a soft helmet 23 hours per day due to the back of his head being flat; HCDSS explored this with medical staff, and found the helmet was not a contributing factor to SC's death. SM reported to HCDSS on the night of 7/21/17, she put SC to bed in his Pack and Play at approximately 7:30PM. SM stated she next checked on SC at 3AM on 7/22/17, and he appeared fine. PS reported he awoke at 5AM to check on SC, and discovered SC felt warm; SC was swaddled and had a diaper on. PS stated he unwrapped SC's arms and placed the blanket just over SC's legs. PS then gave SC a bottle of ice water to cool him down, which both SM and PS reported they would do often, and then PS went back to bed. PS stated when he awoke again at 9AM, he found SC lying on his back with the blanket over his chest; SC's head was not covered, and it appeared SC had vomit on his face. PS stated SC felt cold to the touch and "a little stiff", and that is when he left SC's room and told OA to call 911. PS then awoke BM. EMS arrived at the home shortly thereafter and transported SC to the hospital, where he was pronounced deceased. There was no discussion surrounding safe sleep or if the caregivers had been educated surrounding such. The record also did not reflect how SC was normally placed to sleep.

HCDSS interviewed BF1 via phone, and he had no concerns regarding SM's care of SC. HCDSS completed a home visit to meet with BF2, as well as to observe and interview SS. There were no safety concerns noted during the home visit or the interviews. HCDSS offered all family members appropriate services. The family reported they would consider services but did not accept at that time.

HCDSS spoke with a nurse at the pediatrician's office regarding concerns SM and PS had been giving SC ice water in a

bottle. The nurse explained that is not something they would ever recommend for a child that young, and SC's chart did not note any recommendations that he be given water. HCDSS attempted to ask the pediatrician about this matter, but she refused to comment. HCDSS brought this to the attention of the ME, and the ME reported it would be explored further. HCDSS also followed up with the neurologist who prescribed SC's helmet. SC was scheduled to see that doctor on an as needed basis, and there were no concerns noted regarding SC or his care.

Throughout the investigation, HCDSS contacted an array of collateral sources, including LE, the ME, EMS, medical staff, family members and friends. At the time of this writing, the cause and manner of death were not yet determined; however, preliminary autopsy results showed no physical injury or trauma to SC. There were no criminal charges filed against SM or PS. HCDSS had no evidence to substantiate the allegations against SM and PS, and therefore appropriately unfounded and closed the investigation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: This fatality investigation was conducted by the Herkimer County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Herkimer 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
043061 - Deceased Child, Male, 10 Mons	043063 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
043061 - Deceased Child, Male, 10 Mons	043064 - Mother's Partner, Male, 25 Year(s)	Inadequate Guardianship	Unsubstantiated
043061 - Deceased Child, Male, 10 Mons	043064 - Mother's Partner, Male, 25 Year(s)	DOA / Fatality	Unsubstantiated
043061 - Deceased Child, Male, 10 Mons	043063 - Mother, Female, 26 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

Additional information:
HCDSS interviewed relevant collateral contacts and obtained information surrounding the events leading up to SC's death. SC's BF was interviewed via phone. There were no attempts to interview OA, or establish if he was a caretaker for the CHN.

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	☒	☐	☐	☐

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?	☐	☒	☐	☐
Explain as necessary: The SS did not need to be removed as a result of this fatality report or for reasons unrelated.				

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:
Services were offered to the family, but the family had not yet engaged by the time the case closed.

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:
HCDSS referred the SS to counseling at the local CAC; however, at the close of the investigation, he had yet to engage in services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
HCDSS referred the family to grief and counseling services; however, at the close of the investigation, they had yet to engage in services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? 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? No

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/28/2016	Other Child - Unrelated CH, Female, 5 Years	Mother's Partner, Male, 25 Years	Inadequate Guardianship	Unfounded	No
	Other Child - Unrelated CH, Female, 3 Years	Mother's Partner, Male, 25 Years	Lack of Supervision	Unfounded	
	Other Child - Unrelated CH, Female, 5 Years	Other Adult - PS's previous Girlfriend., Female, 21 Years	Inadequate Guardianship	Unfounded	
	Other Child - Unrelated CH, Female, 5 Years	Other Adult - PS's previous Girlfriend., Female, 21 Years	Lack of Supervision	Unfounded	
	Other Child - Unrelated CH, Female, 3 Years	Other Adult - PS's previous Girlfriend., Female, 21 Years	Lack of Supervision	Unfounded	
	Other Child - Unrelated CH, Female, 5 Years	Mother's Partner, Male, 25 Years	Lack of Supervision	Unfounded	
	Other Child - Unrelated CH, Female, 3 Years	Mother's Partner, Male, 25 Years	Inadequate Guardianship	Unfounded	
	Other Child - Unrelated CH, Female, 3 Years	Other Adult - PS's previous Girlfriend., Female, 21 Years	Inadequate Guardianship	Unfounded	

Report Summary:
This report was received with concerns PS and his then girlfriend (GF), failed to supervise children in their care (ages 5 and 3, unrelated to SC), and as a result, the CHN were found unattended on a street nearby the home.

Determination: Unfounded **Date of Determination:** 01/09/2017

Basis for Determination:
HCDSS completed interviews and home visits, and discovered PS and GF had 1055 custody of the two CHN. The CHN left the home alone at approximately 8AM on 12/28/16. At the time, PS and GF were asleep. They were aware the CHN were awake and playing in their room prior to falling back asleep and leaving them unsupervised. The front door of the home was unlocked, and the CHN left because they wanted to go visit their mother. The CHN were found on a surrounding street and taken to the police station. HCDSS worked with PS and GF to install door alarms and review supervision. HCDSS determined it was a one time incident and closed the case.

OCFS Review Results:
The investigation met all statutory requirements. HCDSS indicated the case; however, the determination was overturned via Fair Hearing. Therefore, the final determination is noted as unfounded.

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

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

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

Known CPS History Outside of NYS

It is unknown if there is CPS history outside of NYS. SM and the CHN lived in North Carolina for a time period; however, HCDSS did not conduct a CPS history check in that 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