NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-15-024 **Prepared by: New York City Regional Office**

Issue Date: 9/14/2015

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
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
CPR-Cardio-pulmonary Resuscitation		
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	MN-Medical Neglect	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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Manhattan
Gender: Male
Date of Death: 03/30/2015
Initial Date OCFS Notified: 03/30/2015

Presenting Information

On 3/30/15, the SCR registered a report which alleged that the BM smothered the SC in a bathroom of a restaurant. According to the report, the BM and the SC had lunch at the restaurant when the BM locked herself in the bathroom with the SC . The other diners noticed that the BM was in the bathroom for a long time and notified an employee who unlocked the door. The BM was found crying at one end of the bathroom; the SC was unresponsive on the floor. The report noted that the SC was pronounced dead and the BM was arrested. It was unknown why the BM murdered the SC.

The SCR registered a duplicate report alleging that an employee became suspicious when the BM and SC remained in the restroom for a long period and called 911. The FDNY and EMS responded to the restaurant and broke down the door. The SC was unconscious. The BM admitted to smothering the SC with her hands because she wanted him to stop crying.

Executive Summary

The SC was twenty months old when he died on 3/30/15. The autopsy listed the cause of death as strangulation and the manner homicide.

On 3/30/15, the SCR registered a report for allegations of DOA/Fatality and Inadequate Guardianship of the SC by the mother.

The mother became known to ACS and the Manhattan Family Court (MFC) in 2007 concerning the custody of the SC's sibling. During years of involvement with the mother, ACS learned that the mother had serious clinical issues for which she had not received ongoing treatment. ACS ended their contact with the family on 11/28/11 after the MFC granted full custody of the sibling to the sibling's father. The sibling relocated with his father to California in September 2014, but had to visit with the mother and SC three times a year as ordered by the MFC judge.

ACS interviewed the sibling's father via telephone and made arrangements with the California Sheriff's Department to visit their home to assess the child's safety. The Sheriff's Department reported that the sibling who had special needs was safe. ACS made additional collateral contacts with the sibling's service providers and they deemed him safe in the care of his father.

ACS conducted a comprehensive investigation of the report, which included contact with the ME, law enforcement and family members. According to the information gathered from the NYPD and the ADA, the mother arrived at the restaurant at 12:34 P.M. and was observed feeding and playing with the SC. The SC appeared happy. The mother had a glass of wine and stepped out of the restaurant with the SC. The mother re-entered the restaurant at 1:35 P.M. and went to the restroom with the SC. At 2:21 P.M., the restaurant staff knocked on the door of the restroom because it was noticed that she was there for a long period. However, the mother did not respond. At 2:27 P.M., the restaurant staff opened the door with a master key and found the mother sitting on the commode holding the SC who appeared dead. The restaurant staff administered CPR and left the restroom to call 911. EMS found the SC unconscious and

transported him to Bellevue Hospital where he arrived at 3:10 P.M., and pronounced dead at 3:35 P.M.

The mother was arrested and admitted to Elmhurst Hospital. According to ACS' documentation the mother confessed to smothering the SC and was charged with Intentional Homicide. She was later transferred to Riker's Island Rose Singer Center. There was no bail set for the mother.

The SC's father reported that he had never witnessed the mother hurt the SC. He reported that he was aware that the mother had clinical problems, but was not aware of her diagnosis or treatment.

In spite of diligent efforts, the ACS Specialist was unable to interview the mother or assess the family's home due to the mother's clinical health and the fact that the police deemed the home a part of the crime scene.

On 6/29/15, ACS indicated the report based on the mother's admission to smothering the child and her subsequent arrest. The mother remained incarcerated at Riker's Island. After the determination, ACS learned that the mother was being charged with Homicide (Strangulation) in the Second Degree and would return to Manhattan Criminal Court on 9/8/15.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** 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:
N/A

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 mother had no other child in her custody when she was arrested for the murder of the SC.

Required Actions Related to the Fatality

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

Issue:	Failure to offer services
Summary:	The case documentation reflected that the father was not offered services (bereavement counseling or assistance with burial of the child) following the fatality. ACS documented that the father did not keep scheduled appointments in the Manhattan Field Office; however, the documentation reflected that the father often spoke with ACS via telephone and this could have been done via the phone.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
Action:	ACS must meet with the staff involved in this fatality investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a correction action plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/30/2015 **Time of Death:** 03:35 PM

County where fatality incident occurred: MANHATTAN
Was 911 or local emergency number called? Yes
Time of Call: 02:27 PM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Crying

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	No Role	Male	33 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Other Household 1	Sibling	No Role	Male	13 Year(s)

LDSS Response

Following the receipt of the SCR report, ACS conducted a comprehensive investigation of the report, which included contact with the ME, law enforcement and family members. ACS learned that prior to leaving her home on 3/30/15, the mother awoke the SC's father at 8:30 A.M. and went out to get him breakfast. She returned to the home and asked him to stay with her , but he left at 9:00 A.M. to attend a GED program. Sometime later, the mother left the home to go shopping for clothes for the SC. At 12:34 P.M., the mother stopped at a restaurant to have lunch with the SC.

According to images of video cameras from the restaurant, the mother arrived at the restaurant at 12:34 PM, and was observed feeding and playing with the SC who appeared happy. The mother had a glass of wine and stepped out of the restaurant with the SC at 1:24 PM. The mother re-entered the restaurant at 1:35 P.M. and went to the restroom with the SC in the stroller. At 2:21 P.M., the restaurant staff knocked on the door of the restroom after noticing that she was there for a long period. However, the mother did not respond. At 2:27 P.M., the restaurant staff opened the door with a master key and found the mother sitting on the commode holding the SC who appeared dead. The restaurant staff administered CPR and called 911. EMS found the SC unconscious and transported him to Bellevue Hospital where he arrived at 3:10 P.M; he was pronounced dead at 3:35 P.M.

The SC had no physical marks on his body, and appeared healthy. However, his fingernails, onesie, and pants were dirty and his hair matted. In addition, his clothes appeared to be oversized.

The mother was arrested and she made statements to indicate that she had smothered the SC; however, she gave several accounts to explain her actions. The mother said she wanted the SC to stop crying, she felt someone was going to "eat the SC," and that "the devil made her do it." The ADA indicated the mother was tearful, but lucid and coherent. The mother reported that she was receiving mental health treatment, but could not specify the name of the provider. The mother was admitted to Elmhurst Hospital then charged with Intentional Homicide and transferred to Riker's Island Rose Singer Center. The mother was denied bail.

ACS interviewed the sibling's father (who resided in California) by telephone and the California Sheriff's Department visited the home of the sibling's father to assess the child's safety. The sibling, who had special needs, was deemed safe. ACS also made several collateral contacts with the sibling's service providers and they deemed him safe in the care of his father.

The SC's father reported that he had never witnessed the mother hurt the SC and he had no concerns regarding the care the mother had provided to the child prior to this incident. The father said he was aware of the mother's clinical issues, but was not aware of her diagnosis or treatment. The father was not very cooperative and did not keep appointments scheduled with ACS.

ACS made diligent efforts to interview the mother at the hospital and later at the Riker's Island. However, the Specialist was unsuccessful. ACS also made a visit to the case address, but was denied access to the home as it was deemed a crime scene. ACS attempted to interview several staff from the restaurant where the child died, but they declined the interview. ACS was unable to obtain clinical information from the mother's service provider because they did not have a subpoena. However, ACS established a good rapport with the NYPD and were able to obtain crucial information for this investigation.

On 6/29/15, ACS indicated the report based on the mother's admission to smothering the child and her subsequent arrest. The mother remains incarcerated at Riker's Island. After the determination, ACS learned that the mother was charged with Homicide (Strangulation) in the Second Degree and would return to Manhattan Criminal Court on 9/8/15.

Official Manner and Cause of Death

Official Manner: Homicide
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)?No
Comments: ACS' investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
015261 - Deceased Child, Male, 1 Yrs	015262 - Mother, Female, 35 Year(s)	DOA / Fatality	Substantiated
015261 - Deceased Child, Male, 1 Yrs	015262 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☐	☒	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐

Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ACS attempted to interview the BM at the hospital and in jail, but was unsuccessful.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?
☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	Mother	Pending	Pending
Comments:	The mother is currently charged with Section 121.20 (D Felony) Strangulation in the Second Degree and she was not granted bail. She remains at Riker's Island Correctional Facility. She is scheduled to appear at the Manhattan Criminal Court on 9/8/15.		

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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:
In spite of his resistance to meeting with ACS, the father of the SC spoke with the Specialist via telephone. The documentation did not reflect that the SC's father was offered services.

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? N/A
Explain:
The SC's sibling resided with his BF outside of NYS. ACS confirmed with the sibling's therapist that he was engaged in therapy. The sibling's BF consulted with the therapist for guidance in disclosing the death of the SC.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The father did not meet with ACS, but via telephone he noted that he was scheduled to receive therapy. It was not specified whether he sought this service for bereavement reasons.

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

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)
06/03/2014	4191 - Other Child - Half-Sibling, Male, 12 Years	4192 - Stepmother - Half-Sibling, Female, 38 Years	Inadequate Food / Clothing / Shelter	Unfounded	Yes
	4191 - Other Child - Half-Sibling, Male, 12 Years	4192 - Stepmother - Half-Sibling, Female, 38 Years	Inadequate Guardianship	Unfounded	

Report Summary:
On 6/3/14 the SCR registered a report with allegations of IFCS and IG of the mother's then 12-year-old child. The subject of the report was the child's step-mother. According to the narrative of the report, the child resided with his step mother who had custody of him; however, the stepmother did not feed the child anything during the week; he was only fed at school and as a result the child was always hungry. The report further stated that the child ate when he visited his mother's home on weekends.

ACS investigated the report and made contact with the mother of the 12-year-old child. The mother provided details regarding her clinical health, details regarding the removal of the 12-year-old child and the custody case in the Manhattan County Family Court. In addition to observing the child in the home and at school, ACS made the appropriate collateral contact with the school, medical providers, court, and family members. ACS confirmed information regarding custody, and learned that the child was well-cared for.

Determination: Unfounded | **Date of Determination:** 07/14/2014

Basis for Determination:
There was no credible evidence to substantiate the allegations of IFCS and IG of the SC by the child's step mother. ACS documented that the conditions alleged in the SCR report did not exist as the child appeared healthy and well cared for.

OCFS Review Results:
The investigation of the report commenced within the mandated timeframe. ACS made contacts with the appropriate collaterals and assessed that the child was safe in the home of his stepmother.

OCFS' review of the Safety Assessments pertaining to this report/case reflected that ACS documented that there were safety factors present but these factors did not place the child in immediate or impending danger of serious harm. ACS identified those factors as the prior history of the BM, and the BM's clinical history which included the history of violence. The BM was not the subject of the report and the child was not in her home. The Safety Assessment did not include an assessment of the step mother's home or her interaction with the child.

While investigating the 6/3/14 report, ACS learned that the BM had given birth to a male child in 2013 and the child was residing with the BM. While there was no legal requirement for ACS to visit the mother's home, it would have been good case practice for ACS to see this child as part of the collateral contact given the mother's prior CPS history and involvement with ACS.

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

Issue:

Determination of Nature, Extent and Cause of Conditions (Report)

Summary:

During the course of the 6/3/14 investigation which involved the BM's 12-year-old child, ACS learned that the mother had given birth to a male child who was now one year old. ACS had not seen this child because their involvement with the family had ended in 2011. However, given the age of the child and the mother's prior CPS history, ACS should have contacted the SCR to report their concerns.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(d)

Action:

The Administration for Children's Services (ACS) must submit a corrective action plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

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

The BM was known to the SCR and ACS as a maltreated child in two indicated reports. As an adult, the family's CPS history involved the deceased child's sibling. The family became known to ACS in 2007 when the Manhattan Family Court (MFC) requested an investigation (COI) on a custody petition filed by the sibling's father. The record indicates that ACS was to determine whether there was a need to file an Article 10 Petition for this case. During this 2007 COI, the father expressed concerns for the safety of the sibling given the mother's alleged drug use and behavior; however, the mother's drug screens were negative. The father reported that the mother had threatened to kill him and an order of protection (OOP) was issued on his behalf. No details of the OOP were documented.

Both parents reported allegations of domestic violence in their relationship. The investigation revealed that in 2005 the mother threw hot oil on the father while he slept. The sibling was reportedly in the home. The NYPD responded to the home; however, the father did not press charges. The mother was taken to the hospital where she was admitted for mental health issues. No report was registered with the SCR in 2005.

ACS closed the COI on 10/29/07 without recommending an Article 10 Petition. The sibling remained with the mother and the custody case remained active.

On 3/19/09, the SCR registered a report with allegations of Burns, Scalding, and Inadequate Guardianship of the sibling by the mother. During this time, the parents shared joint custody of the sibling. The sibling had a mark on his chest that appeared to be a cigarette burn. The report was unfounded based on the medical information provided by the sibling's pediatrician and the CAC. It was determined that the mark was the result of a skin condition.

On 3/21/11, the SCR registered a request for a COI with allegations of IG of the sibling by his parents. ACS' investigation revealed that on 3/14/11 the mother showed up at the father's job unannounced to ask him to keep the sibling. The father

reported that the mother who was incoherent, alleged that people were chasing her and that she felt she was in danger. The father kept the sibling and did not hear from the mother; therefore, he returned to Family Court on 3/21/11 for sole custody.

ACS learned that the mother was admitted to Jamaica Hospital on 3/15/11 after she attempted suicide. This was the mother's second attempt to commit suicide within the previous six years. It was revealed that the mother had a history of untreated mental health concerns. ACS reviewed the mother's mental health history dating back to 2005 and discussed her multiple diagnoses. It was determined that the mother was unable to care for the sibling.

On 4/12/11, ACS filed an Article 10 Petition of Neglect on behalf of the sibling naming the mother as the respondent. The sibling was released to the father with an Order of Protection against the mother barring her from interfering with his parenting of the sibling. The mother was subsequently discharged from the hospital and referred to a partial hospitalization program (PHP).

On 4/14/11, ACS indicated the report against the mother due to her mental health issues for which she was not receiving treatment. The report was unfounded against the father.

From 4/5/11 through 11/28/11 ACS' Family Services Unit (FSU) monitored visits with the mother and the sibling and assessed the care the father was providing. The case remained active in MFC with the FSU providing updates to the court. The mother was not consistent with her mental health appointments, but visited the sibling regularly. In September, the mother was arrested for assaulting her aunt. The mother was incarcerated at the Rikers's Island Rose Singer facility. During the mother's incarceration the father gained custody of the sibling.

Known CPS History Outside of NYS

The family had no CPS history outside NYS.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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