Child Fatality Report

Report Identification Number: NY-18-034

Prepared by: New York City Regional Office

Issue Date: Oct 02, 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: 8 year(s)
Jurisdiction: Richmond
Gender: Female
Date of Death: 04/03/2018
Initial Date OCFS Notified: 04/04/2018

Presenting Information

The report alleged on 4/3/18 at about 12:45 P.M, the SC was found unconscious by an unknown person, and the mother was not with the SC when she was found far from the home. The report stated the SC was transported to Richmond University Medical Center (RUMC) where she was later pronounced dead. The report alleged there was no explanation for the SC's death and that the SC probably had an unknown medical condition.

Executive Summary

The SC was 8 years old when she died on 4/3/18. The autopsy listed the cause of death as acute viral myocarditis and the manner of death as natural.

The SC resided with her mother who had no other children. The SC had regular contact with her father who had two children from other relationships. The mother had no contact with the father's other children. At the time of the SC's death, the family (mother and SC) had an open investigation dated 2/12/18.

On 4/4/18, the SCR registered a report concerning the death of the SC. The allegations of the report were DOA/FATL, LMC, and IG of the SC by the mother.

ACS initiated the investigation within the required time frame and interviewed family members. ACS also visited the father who had two other children and assessed they were safe in the care of their respective mothers.

ACS learned the SC had been staying with the MA since 4/2/18 and there was no concern about the SC's demeanor prior to the incident that led to her death. According to the mother and family members, on 4/3/18 the SC was with the MA on the way to the local store when she fell in the street. After the SC fell, she and the MA returned to the MGGM's home where the MA reported the SC appeared to be "a little bit off". The MA called the mother who came to the MGGM's home and began to get ready to take the SC to the hospital. The SC became "stiff and could not move;" therefore, the MA called 911. The mother attempted to resuscitate the SC to no avail. EMS arrived at the case address and transported the SC to RUMC.

Upon arrival at the hospital, the SC was taken to the ICU where efforts to stabilize the SC in order to transfer her to a hospital that could provide a higher level of care. However, efforts failed and the SC was pronounced dead at 8:11 P.M.

The NYPD reported there was no criminality concerning the death of the SC; therefore, no arrest was made in this case.

The medical staff at the RUMC found no sign of abuse or maltreatment of the SC. The results of medical examinations at the hospital were normal. The SC appeared to be well cared for with no visible marks or bruises. ACS made additional medical collateral contacts and learned the mother had not been diligent with keeping medical appointments for the SC or following up with medical treatment for a pre-existing condition.

On 7/25/18, ACS substantiated the DOA/FATL allegation based on the mother's negligence in following up with the SC's pre-existing medical condition, and the inconsistency with obtaining routine medical for the SC. However, these issues did not support the allegation determination for DOA/FATL as the SC died of natural causes. ACS utilized the same information to substantiate the allegation of LMC and IG.

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:
N/A.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ACS substantiated the allegations of the report, but did not provide a relevant determination narrative to support the decision for each allegation.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
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 Performance Improvement 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

Child Fatality Report

Date of Death: 04/03/2018 **Time of Death:** 08:11 PM

County where fatality incident occurred: Richmond
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: Out walking with MA.

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: 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	Female	8 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

On 4/4/18, ACS visited the MGGM's home and interviewed family members. The MA reported the SC appeared well up until 4/3/18 when they were on their way to the store and the SC fell. The MA said she helped the SC up and they reached the store where she gave the SC water; the SC appeared well and they walked back to the MGGM's home. The MA said the SC sat on the couch and as they conversed, the SC appeared to be a "little bit off". Therefore, the MA called the mother who was not far from the home.

The mother said when she arrived at the MGGM's home sometime between 1:00 P.M. and 2:00 P.M., the SC was lying on the sofa and her stomach appeared bloated. The mother said she told the SC that she was going to take her to the hospital then went to another room to get a bag for the SC. Shortly after, the MA noticed the SC was "stiff" and called out for the mother. The mother said she ran to attend to the SC who appeared to have had an episode stemming from a pre-existing condition; the SC was lying on the couch with her arms "curled up" and was not moving. The mother demonstrated her efforts to revive the SC and said she yelled out for the MA to call 911. The mother said once EMS arrived they administered CPR, and transported the SC to the hospital.

The medical staff from RUMC reported the SC arrived at the hospital unconscious, with a slow heartbeat, and had no fever. Efforts to resuscitate the SC were to no avail. The medical team said the SC was clean, had no marks or bruises, and no signs of maltreatment. Medical staff performed a CAT scan which revealed the SC had an edema on the left side of the

brain which was swelling. The doctor reported this type of injury could have been caused by "anything" including a fall. There was no information provided that would indicate the SC's pre-existing condition caused the SC's reaction. The doctors had no information concerning the cause of death.

ACS contacted the EMS liaison who stated the 911 call was made at 12:45 PM, EMS arrived at the home at 12:47 P.M. and found the family was very hostile and uncooperative. EMS requested police assistance in order to attend to the SC who was not breathing and had no pulse when they arrived. EMS administered CPR, but the SC began to gag, and she was transported to the RUMC where they arrived at 1:12 P.M.

According to the mother, the SC stayed with her father on 3/31/18 to 4/1/18. The mother said they video chatted and the SC appeared fine. The mother said she picked up the SC from the father's home and then went to the MGGM's home where the family took pictures of the SC in her Easter outfit.

On 4/4/18, ACS visited the home of the SC's father and observed his other two children. The father had no concerns about the care the SC's mother provided for the SC. The father said they had an informal arrangement regarding his visitations with the SC. The father confirmed the SC was at his home from 3/31/18 to 4/1/18 and appeared fine. The father and other relatives stated the SC did not complain of any pain.

ACS obtained medical records for the SC and determined the mother had not obtained routine medical care for the SC.

ACS contacted the SC's school guidance counselor who reported she had no concerns about the level of care the mother provided to the SC. The SC was not performing at grade level and it had been recently recommended that the mother take the SC to see a medical specialist. The GC provided a letter for the mother to take to the SC's doctor to address this issue. There were concerns about the SC's lateness, but ACS did not explore this issue further during this discussion. There was no inquiry about the SC's medicals.

ACS continued contact with the ME and confirmed early in the investigation that the SC had no external or internal injuries. The ME stated there were no signs of trauma or maltreatment.

On 7/25/18, ACS indicated the report.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a 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)?No
Comments: The 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

047053 - Deceased Child, Female, 8 Yrs	047054 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
047053 - Deceased Child, Female, 8 Yrs	047054 - Mother, Female, 26 Year(s)	Lack of Medical Care	Substantiated
047053 - Deceased Child, Female, 8 Yrs	047054 - Mother, Female, 26 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

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? 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	☐	☐	☐	☐	☐	☒	☐

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 mother had no surviving children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The mother had no immediate needs for services after the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
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)	Allegation Outcome	Compliance Issue(s)
02/12/2018	Deceased Child, Female, 8 Years	Mother, Female, 26 Years	Lack of Medical Care	Substantiated	Yes
	Deceased Child, Female, 8 Years	Mother, Female, 26 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 8 Years	Mother, Female, 26 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
The report alleged the mother left the SC alone in the home for up to six hours at a time while she went out to "party". The report also alleged that due to the SC's age she was in need of a higher level of supervision, which the mother was not providing. The report further alleged the SC was seen dirty and without a jacket during the cold weather on more than one occasion. There were also concerns that there was no food in the home and the SC was missing meals. The report stated there was traffic during the night and day in the home; however, there was no suspicion of drug or alcohol use by the mother.

Report Determination: Indicated | **Date of Determination:** 04/16/2018

Basis for Determination:
ACS substantiated the allegations of LMC and IG based on the fact that the mother had not taken the SC to see her pediatrician since 2015. The SC's immunizations were not up to date. The mother had not taken the SC to see a medical specialist since April 2010. However, there was no narrative to support the substantiation of IG.

ACS unsubstantiated the allegation of LS and cited the SC was never left alone as the mother had family members who assisted her with the supervision of the SC.

OCFS Review Results:
ACS initiated the investigation timely; and appropriately added the allegation of LMC. ACS also made relevant collateral to address the allegations listed in the report. The information in the RAP was approved although it was not consistent with the case circumstances.

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

Issue:
Failure to Provide Notice of Indication

Summary:
The CONNECTIONS event list did not reflect Notices of Indication (NOIs) were issued to the parents.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The responses for the questions in the RAP were either incorrect or not explored. This impacted the overall risk rating.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
ACS selected a safety decision that reflected there were safety factors that did not rise to the immediate danger of serious harm. However, by this time the SC who was the only child in the home had died.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Appropriateness of allegation determination
Summary:
ACS substantiated the allegation of IG, but did not provide a narrative to support this determination.
Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/24/2015	Deceased Child, Female, 5 Years	Mother, Female, 24 Years	Lacerations / Bruises / Welts	Unsubstantiated	Yes
	Deceased Child, Female, 5 Years	Mother, Female, 24 Years	Excessive Corporal Punishment	Unsubstantiated	

Report Summary:
The report alleged the mother hit the SC with a broom and as a result the SC sustained bruising on her foot and arm. The report alleged the mother hit the SC as a means of discipline. There were 4 other children, who had no roles, listed in the report.

Report Determination: Unfounded | **Date of Determination:** 05/20/2015

Basis for Determination:
ACS unsubstantiated the allegations of EXCP and L/B/W of the SC by the mother. ACS cited the SC was taken to the Child Advocacy Center for a forensic interview and was unable to explain what happened to her ankle. ACS also cited the NYPD did not make an arrest concerning this matter.

OCFS Review Results:
ACS initiated the investigation timely. However, the investigation was not thorough. The documentation did not provide a description of the SC's injury. It was not clear how ACS determined the other 4 children listed in the report were the SC's "imaginary friends".

ACS interviewed the SC's father, but did not issue a NOE, include him in the RAP, or add him to the person list in CONNECTIONS. ACS contacted the source and other collaterals, but did not make relevant inquiries. The 7-day safety assessment was completed incorrectly.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
The responses for the questions in the RAP were not properly explored. In addition, the father was not added as a secondary caretaker.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
Although there were no safety factors documented, ACS selected a safety decision that reflected there were safety factors that did not rise to the immediate danger of serious harm. The safety factor selected was not supported by the documented comments.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
The investigation was not thorough, there was no description of the SC's injury. Investigative steps to determine the other children were the SC's "imaginary friends" were not evident. Supervisory notes did not reflect relevant directives.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to provide notice of report
Summary:

ACS did not issue a Notice of Existence (NOE) to the father.

Legal Reference:

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

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

ACS contacted the source and other collaterals, but did not conduct interviews focused on clarifying information germane to the allegations made to the SCR or assess the risk and safety of the SC.

Legal Reference:

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

Action:

ACS must meet with the staff involved in this investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

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

The family had no CPS history during this period.

Known CPS History Outside of NYS

The family had no known history outside 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