Child Fatality Report

Report Identification Number: RO-17-022

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

Issue Date: Dec 04, 2017

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: 2 month(s)
Jurisdiction: Steuben
Gender: Male
Date of Death: 06/18/2017
Initial Date OCFS Notified: 06/18/2017

Presenting Information

An SCR report alleged the SM and SF shared a bed with the 9-week-old SC on the night of 6/17/2017. At approximately 2:00 AM on 6/18/2017, the SM fed the SC and laid him back down on a pillow next to her in the bed. The SM awoke around 7:30 AM and found the SC unresponsive. The SC was found on his left side with his face between the SM's pillow and the pillow on which he had been sleeping. The SM called 911 and began CPR. EMS responded to the home but the SC was unresponsive and pronounced dead at 9:18 AM. The roles of the SS, ages 6 and 3, were unknown.

Executive Summary

On 6/18/17, Steuben County Department of Social Services (SCDSS) responded to an SCR report regarding the death of SC, which occurred earlier that day. SM and SF were allegedly responsible for the death, as SC was found affixed between two pillows after bed-sharing.

Based on observations and information from LE, SCDSS learned that following a 2AM feeding, SM placed SC on a normal sized pillow positioned length-wise next to her on the queen-sized bed, and used a body pillow herself, positioned horizontally at the head of the bed. The pillow on which SC slept was positioned between SM and the crib, which was pushed up against the mattress. SF slept on the other side of SM. SM placed SC to sleep on his back, and found him on his side wedged between the two pillows, unresponsive, around 7:30AM. SM and SF responded by calling 911 and attempted CPR. The two SS, ages 3 and 6, were asleep at the time. Efforts to revive SC were made by EMS, but were unsuccessful, and were instructed to cease prior to arrival at the hospital.

The parents reported SC occasionally slept with them in their bed for fear he would choke in the night. They acknowledged prior instances where SF had to alert SM that SC had rolled off the pillow, on which he was regularly placed to sleep in their bed. They noted weeks prior to the death, SC had choking issues, presenting concern enough to address with medical professionals. On 4/26/17, SC was hospitalized for observation and testing (including a full cardiology exam). Records showed no abnormalities or problematic events. The issue appeared to be remedied when SC's formula was changed. SC's pediatrician confirmed SC had no medical conditions that could be linked to his death, and noted no concerns for follow-up care. The pediatrician was asked if the cause of death was medical or due to unsafe sleep, and he would not say without the autopsy report.

During the investigation, SCDSS worked jointly with LE. Though the results of the autopsy were not completed, SCDSS gathered information regarding LE's investigation. LE shared that without the ME's report, it appeared to be a case of unsafe sleeping based on the facts and observations noted thus far.

Immediately following the fatality, PGM assisted in the care of the SS, and the parents utilized her as a safety plan. SM was hospitalized for making suicidal threats and came to receive in-patient MH services for trauma associated with the fatality. After being released from the hospital, SM attempted to harm herself and was re-hospitalized. That same evening, SF drank alcohol then could not be located for several hours. The SS were with PGM at the times of their parents' actions and were not impacted. The safety plan was discussed again, and a decision was agreed to continue it. Further, the parents agreed not to be under the influence of drugs or alcohol in the presence of the SS. On a later date, when appropriate, the safety plan was lifted. SCDSS reassessed, revealing both parents could care for the SS without another adult's support. SCDSS completed timely and accurate safety assessments, and saw the SS were adequately protected throughout the

investigation.

SCDSS offered services to the family, and a voluntary Preventive Services case was opened. Efforts were made to engage the family. SM continued to receive MH services, and the Preventive worker sought services for the SS.

The investigation was closed and UNF, though SCDSS gathered some credible evidence to substantiate the IG allegation. The investigation was incomplete in that appropriate questions were not adequately addressed with collaterals who could have offered a professional opinion, even if preliminary, to assess how SC died. In response to the associated citations, SCDSS will submit a PIP to the Regional Office within 30 days identifying what action SCDSS has taken, or will take, to address this. If a PIP is currently in place, SCDSS will review the plan and revise as needed.

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:
Some credible evidence was found to support the IG allegations contained in the report, but the report was unfounded.

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:	The case record reflected SCDSS gathered some credible evidence upon which to substantiate the allegation of IG; however, the report was unfounded and allegations unsubstantiated.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	SCDSS will take into consideration all information gathered during the investigation when applying the circumstances to the definition(s).
Issue:	Overall Completeness and Adequacy of Investigation
Summary:	The investigation was incomplete in that appropriate questions relating to cause of death were not adequately addressed with collaterals who were in a position to offer a professional opinion, even if preliminary, in order to assess how the SC died. Additional Legal Reference: 13-OCFS-LCM-01
Legal Reference:	SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:	CPS has the responsibility to investigate causation in cases of child fatalities. In all cases, CPS should address the issue of causation with the ME or coroner; if they do not or cannot give an opinion on causation, then CPS will make the causation determination based on the facts before it, consulting with other medical professionals and law enforcement.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/18/2017 **Time of Death:** 09:18 AM

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

County where fatality incident occurred: Steuben
Was 911 or local emergency number called? Yes
Time of Call: 07:32 AM
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
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Other Household 1	Other Adult - 6-year-old SS's BF	No Role	Male	27 Year(s)

LDSS Response

On the date of the report, SCDSS met LE at the family's home where the incident took place. SCDSS observed the scene and gathered pertinent information about the fatality from LE. SCDSS discussed the family's temporary safety plan with SF, which comprised of the 2 SS being cared for with another adult present for support. PGM was the identified resource; SCDSS spoke with her as well. The safety plan was devised because SM had been transferred to the hospital following the fatality for making suicidal threats. SCDSS later met with SM at the hospital, briefly discussed the events surrounding the fatality, and confirmed the safety plan. SCDSS verified SM would be released with proper information regarding crisis MH services in case it was needed.

PGM continued to care for the SS while needed by the family. SCDSS appropriately addressed arising concerns and addressed them promptly with the family to verify adequate protection of the children. SCDSS interviewed both SS, and no concerns were revealed.

Based on statements obtained, SCDSS learned the events leading up to the fatality. The parents reported SC had a history of choking though he had no attributing medical ailments. This appeared to be remedied by changing his formula. Though a crib was available directly adjacent to the parents' bed, the SM and SF shared their bed with SC. SM's rationale was she wanted to have SC close to her in case he choked in the night. On 6/18/17 around 2AM, SM fed SC for about 30 minutes then placed him to sleep on his back on an adult pillow, perpendicular and adjacent to the body pillow upon which she had her head. When SM awoke around 7:30AM, she found SC on his side, wedged between the two pillows, unresponsive. SF reported he had fallen asleep in the bed they shared around 10PM while SM was still awake feeding SC in a chair, and did not wake up until the next morning when SM was screaming. Though SF did not see how SC was placed to sleep, he acknowledged they shared their bed with SC. Upon discovery of SC's unresponsiveness, SM called 911 and administered CPR as instructed. EMS could not revive SC. SCDSS spoke with the neighbor whom SF alerted for assistance that morning. SCDSS learned from the parents and collaterals that the parents were aware of recommended safe sleep practices. First responders corroborated SM's account of how SC was found wedged between the two pillows that were part of the sleeping environment in which he was placed by SM.

Despite the information obtained, SCDSS UNF the report. SCDSS noted the reason was SM was trying to protect SC, and stated, "a reasonable and prudent parent, exercising a minimal degree of care, faced with like circumstances as (SM) and (SF), would have acted in a similar fashion." OCFS disagrees; with an alternate, safe environment available for the SC to sleep in, which was in immediate proximity to the SM, it is evident the choice was made to place the SC in the setting that was unsafe. There was no documented medical basis to conclude bed-sharing was the safer alternative; the parents were

never advised to do so. Irrespective of the death, the vulnerable infant was placed in imminent danger of serious harm/significant impairment. Additionally, SCDSS failed to ask questions of medical professionals that could have led to an understanding of the nexus between the environment in which SC was placed and the restrictive items which were found surrounding him. Had consultation been held to discuss the facts of how SC was found in relation to a professional opinion (even if preliminary) regarding a 2-month-old child's ability to breathe while affixed between pillows, there would be a basis to show that a complete investigation was done into the element of causation.

SCDSS gathered information from collateral contacts such as neighbors, family, hospital staff, LE, and all first responders. SCDSS offered services to the family, many of which were accepted. The Preventive Services case remained open.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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 targeted report was jointly investigated with the appropriate law enforcement entity, in compliance with 06-OCFS-ADM-08.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041501 - Deceased Child, Male, 2 Mons	041503 - Father, Male, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
041501 - Deceased Child, Male, 2 Mons	041503 - Father, Male, 29 Year(s)	DOA / Fatality	Unsubstantiated
041501 - Deceased Child, Male, 2 Mons	041502 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
041501 - Deceased Child, Male, 2 Mons	041502 - Mother, Female, 27 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The person named as SS's BF was attempted to be notified in writing, but the letter was returned as undeliverable. During investigation, documentation proved he was not the BF to any child; therefore, a face-to-face interview was not pursued.

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: No removal was necessary regarding the surviving siblings.				

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	Needed but 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:
SM was provided services with Health Homes of Upstate New York to assist with MH services. The parents utilized services offered for the funeral and cremation of the SC. Family Preservation Preventive Services were offered and accepted following the fatality. Family Planning could have benefitted the family due to statements made by SM, regarding her fears with the subsequent pregnancy.

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? Yes
Explain:
The two SS were referred for MH services pertaining to possible impact of the fatality. One SS received additional services with the school social worker. The family participated in Family Preservation Preventive Services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM received MH services and continued assistance from Health Homes of Upstate New York. Parents were referred to grief counseling; SF refused, and SM received trauma counseling through her MH provider. The family also participated in Family Preservation Preventive Services, though engagement was limited due to the SM's changing work schedule. Parents were provided assistance with finances pertaining to the fatality.

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 fetal alcohol effects or syndrome
☒ With neither 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

SM and SF have no CPS history more than 3 years prior to the fatality. The SS who is now age 6 was listed as a non-confirmed maltreated child on a report dated 4/15/2014. The unsubstantiated allegations were against a relative caregiver/babysitter. There was no other history during this time for either SS.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

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.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Additional Local District Comments

The passing of this child has no explanation at this time; the ME's report is not yet complete, and collaterals, including LE and the child's physician offered no causal connection between the death of the child and the sleep environment. Should the ME's report indicate a causation for the death of the child, SCDSS will review the possibility of making another report regarding the fatality. SCDSS's investigation was complete and took into consideration the totality of the circumstances. SCDSS investigation included direct contact with the family, the scene of the fatality and the collaterals. SCDSS furthermore specifically utilized and followed the guidance of the OCFS in the LCM's regarding fatalities, paying particular attention to the guidance surrounding sleep related fatalities/injuries.

It should be noted, SCDSS was in direct consultation with the OCFS reviewer of the fatality report. Up until the final determination by SCDSS, unfounding the case, no citations were identified in the first draft. The final report cites SCDSS for lack of completeness/adequacy of the investigation when the investigation information, specifically the collateral contacts were the same and acceptable had SCDSS indicated the case. Given this, SCDSS does disagree with the citations as listed in this report.

Good casework practice allows for, and in fact demands, engagement, understanding of underlying conditions, history and the culture of each family and should disregard any inquiry of intent. Furthermore, good casework practice, taking into consideration all those things, must, as detailed in the guidance, include the surviving family member(s) well-being and needs.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☒Yes ☐No

Action:	It is recommended SCDSS review and adhere to the guidelines set forth in the respective LCMs pertaining to unsafe sleep recommendations and implications therein regarding death and risk of harm (10-OCFS-LCM-15 and 13-OCFS-LCM-01). It is imperative to ask the appropriate questions of necessary collateral contacts and make decisions in accordance with such standards. The guidance contained in the documents also frame a local district's requirement to make well-informed, accurate determinations despite the known possibility of further trauma to those being held responsible.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No