Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-25-042

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

Issue Date: Nov 14, 2025

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

- ☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- ☐ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.
- ☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- ☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grandmother	MGF-Maternal Grandfather	FF-Foster Father
PGM-Paternal Grandmother	PGF-Paternal Grandfather	DCP-Day Care Provider
MGGM-Maternal Great Grandmother	MGGF-Maternal Great Grandfather	PGGF-Paternal Great Grandfather
PGGM-Paternal Great Grandmother	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-Caseworker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Tompkins
Gender: Female
Date of Death: 08/07/2025
Initial Date OCFS Notified: 08/07/2025

Presenting Information

An SCR report alleged on 8/7/25, around 2:00AM, the father put the 2-month-old sleeping child in her bassinet. The mother checked on the child at 7:50AM and found her to be purple, with blood and mucus coming from her nose. The child regained color after the mother suctioned her nose. The mother called 911 and performed CPR. The police arrived at the home and continued CPR. EMS arrived at the home and took over. The child was pronounced deceased at 8:04AM. A subsequent report alleged, on a daily basis, the mother and father would prop a bottle of milk into the child's mouth with a rolled-up blanket and leave her unsupervised. On 8/7/25, at approximately 3:00AM, the mother and the father did this. At approximately 4:00AM, the mother checked on the child and found her deceased due to choking on the milk. The mother performed CPR on the child for an unknown length of time; however, neither adult called 911 for several hours. At approximately 7:00AM, law enforcement arrived at the home.

Executive Summary

Tompkins County Department of Social Services (TCDSS) received an SCR report regarding the death of the 2-month-old female subject child. At the time of her death, the child resided with her subject mother, subject father and surviving siblings ages 13, 11, and 1 years. The 13 and 11-year-old surviving siblings' fathers resided at their respective residences. TCDSS determined the surviving siblings were safe in the home.

TCDSS learned that the parents had been placing the subject child in an unsafe sleep environment by regularly utilizing blankets to prop the child up. At the time of the subject child's death, she was placed in the bassinet, on a boppy pillow, with blankets under her head. The subject child was found unresponsive by the subject mother. CPR was administered and 911 was called. First responders were unable to revive the subject child, and she was pronounced deceased at 8:04AM.

The final autopsy report listed the manner of death as "Undetermined Circumstances" and the cause of death as "Sudden Unexplained Infant Death". Under the Cause of Death section, the certificate read "Other significant conditions contributing to death but not related to cause: pillow in sleep environment". TCDSS spoke with the responding officers and the detective assigned to the case. After law enforcement spoke with the medical examiner, it was determined their case would be closed and no charges would be filed.

TCDSS substantiated the allegations of Inadequate Guardianship and DOA/Fatality against the subject mother and the subject father regarding the subject child due to determining that the parents were utilizing a nursing pillow and blanket in the child's sleep environment. TCDSS noted that the company that produced the pillow was in litigation due to their noncompliance with recalling the pillow based on findings that it had been related to multiple infant deaths. TCDSS unsubstantiated the allegations of Choking/Twisting/Shaking, Lack of Medical Care, and Lack of Supervision against the parents regarding the subject child as there was no fair preponderance of evidence.

TCDSS referred the family to appropriate grief counseling services and provided bereavement resources. The family declined funeral assistance as they decided not to have a funeral for the subject child.

PIP Requirement

OCFS' review resulted in citations. In response, each cited county will submit a Program Improvement Plan (PIP) to the Regional Office which will identify what action(s) the respective LDSS' have taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, the respective LDSS will review the plan(s) and revise as needed to further address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** No
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Unable to Determine

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:
The allegations of Inadequate Guardianship and DOA/Fatality were appropriately substantiated against the SM and SF regarding the SC. The allegations of Lack of Medical Care, Lack of Supervision and Choking/Twisting and Shaking against the parents were appropriately unsubstantiated regarding the SC.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
TCDSS did not inquire about the fatal incident or ask safety and risk related questions pertaining to potential DV, MH, or substance abuse concerns with the SSs. The SM reported she sometimes used a belt to discipline the children; although she reported, not forcefully. These concerns were not explored with the SSs. Additionally, the family dynamics were not explored with the SSs.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:	TCDSS engaged in rapport building conversation with the SSs; however, did not inquire about the fatal incident or ask safety and risk questions related to DV, substance abuse, MH or potentially being disciplined by the SM with a belt.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	TCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/07/2025 **Time of Death:** 08:04 AM

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

County where fatality incident occurred: Tompkins
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Other Adult - SS's BF	No Role	Male	35 Year(s)
Other Household 2	Other Adult - SS's BF	No Role	Male	32 Year(s)

LDSS Response

TCDSS began their investigation within 24 hours, contacted the sources, and completed a CPS history review. TCDSS interviewed the subject parents, assessed the home, and determined the surviving children were safe in the parents' care.

The parents recounted the events prior to the fatal incident. The subject mother explained she fed the subject child a bottle and then "snuggled" with her on the couch. The subject father noticed the mother falling asleep on the couch with the child, woke her, and put the child in her bassinet. The mother went to sleep around 9:00PM, and the father stayed up. He reported he heard the child "cooing and squeaking" sometime between 2:00AM and 4:00AM. He checked the child's diaper, repositioned her, and she went back to sleep. Around 7:00/7:30AM, the mother went to wake the SSs. When she returned downstairs, she observed the child in her bassinet and her head to look purple with a blackish mucus coming from her mouth and nose. The mother found the child positioned in the bassinet, on the nursing pillow with her face and mouth clearly visible and nothing to indicate she had obstructed airways. The mother ran to get the father, called 911, and began CPR. The mother reported that the child was not cold, and it did not appear rigor mortis had set in. The mother immediately began suctioning mucus from the child's mouth and nose and some of the child's color began to return. First responders arrived and took over life-saving measures. During this, the 13 and 11yo SSs came downstairs and witnessed the scene.

Initially the subject parents reported that they had been practicing "ABC safe sleep guidelines"; however, explained that the subject child did not sleep well until they began using a nursing pillow with a blanket placed over it, to keep the child's head slightly elevated. TCDSS noted that an accurate observation of the child's sleep environment could not be made as the bassinet was disassembled; however, the mother used a pillow and blanket to demonstrate the setup.

Although TCDSS did speak with the 13 and 11yo SSs regarding rapport related questions, there was no discussion pertaining to the fatal incident or safety and risk related questions pertaining to topics such as, family dynamics, discipline, mental health, domestic violence, substance abuse, caretaker responsibilities or the children's needs. The 1yo SS was unable to be interviewed due to age and development.

The first responding officer reported that upon arrival, the child was placed on the couch, and the parents were attempting CPR. The 13 and 11yo SSs were standing nearby and were taken outside by first responders as to not witness the traumatic scene. Law enforcement reported that the nursing pillow the family was using was recalled and in litigation due to the company's refusal to recall the product.

Law enforcement observed a bottle of cleaning solution that was being used to clean the child's mattress to say, "should not be ingested or inhaled by humans". Law enforcement noted when inspecting the infant's body, an "unusual bubbly white substance" coming from the child's nose, which could have been attributed to the chemical/cleaning agents used in the product. The medical examiner initially stated that the cleaning solution could be a concern or could have contributed to the death; however, after an autopsy and toxicology were completed, it was determined there was no evidence to suggest the cleaning solution contributed to the death.

TCDSS completed the Safety Assessments and Risk Assessment Profile based on the information that was collected from the parents; however, did not collect safety and risk information from the SSs. It remained unknown if the Safety Assessment due at the time of determination was accurate as the information was not explored.

Official Manner and Cause of Death

Official Manner: Undetermined

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)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

Comments: Tompkins 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
072709 - Deceased Child, Female, 2 Month(s)	072710 - Mother, Female, 32 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
072709 - Deceased Child, Female, 2 Month(s)	072710 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
072709 - Deceased Child, Female, 2 Month(s)	072710 - Mother, Female, 32 Year(s)	Lack of Supervision	Unsubstantiated
072709 - Deceased Child, Female, 2 Month(s)	072711 - Father, Male, 30 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
072709 - Deceased Child, Female, 2 Month(s)	072711 - Father, Male, 30 Year(s)	Lack of Medical Care	Unsubstantiated
072709 - Deceased Child, Female, 2 Month(s)	072711 - Father, Male, 30 Year(s)	Lack of Supervision	Unsubstantiated
072709 - Deceased Child, Female, 2 Month(s)	072710 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
072709 - Deceased Child, Female, 2 Month(s)	072710 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
072709 - Deceased Child, Female, 2 Month(s)	072711 - Father, Male, 30 Year(s)	DOA / Fatality	Substantiated
072709 - Deceased Child, Female, 2 Month(s)	072711 - Father, Male, 30 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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☐	☒	☐	☐
At 30 days?	☐	☒	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Explain:
Although TCDSS did speak with the 13 and 11yo SSs regarding rapport related questions, there was no discussion

pertaining to the fatal incident or safety and risk related questions pertaining to topics such as family dynamics, discipline, mental health, domestic violence, substance abuse, caretaker responsibilities or the children's needs. The 1yo SS was unable to be interviewed due to age and development.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☐	☒	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
The Risk Assessment was completed; however, the 13 and 11yo SSs were not asked risk related questions; therefore, it is unclear if the assessment is accurate. The family was provided with resources for bereavement services and TCDSS completed a referral.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Have any Orders of Protection been issued? No

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The family reported that they planned to engage in bereavement services; however, had not yet engaged at the time the case was closed. The family declined funeral assistance because they did not have a funeral for the SC.

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The family was provided with bereavement resources and TCDSS completed a referral.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The family was provided with bereavement resources and TCDSS completed a referral.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/28/2023	Sibling, Male, 10 Years	Other Adult - The then 10yo SS's BF, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes

Report Summary:
Monroe County Department of Human Services (MCDHS) received an SCR report that alleged the then 10yo SS frequently would go hungry. His father did not provide food for him, and he had to rely on others to feed him.

Report Determination: Unfounded | **Date of Determination:** 01/20/2024

Basis for Determination:
MCDHS unsubstantiated the allegation of Inadequate Food, Clothing, and Shelter regarding the then 10yo surviving sibling against his father. MCDHS visited the home and observed ample food in the home. The surviving sibling report there was always food in the home and a collateral contact reported that the surviving sibling had never reported a food shortage.

OCFS Review Results:
MCDHS began their investigation within 24 hours, contacted the source, and completed a CPS history review. MCHDS visited the then 10yo SS at school, interviewed him, assessed the home, and interviewed his father. MCDHS spoke with school staff and requested medical records. The SS relocated to the SM's and MCDHS requested that TCDSS complete a home assessment. TCDSS assessed the SS, the SM's home and interviewed the SM. MCDHS did not add a household member to the case or notify and interview him. The Risk Assessment Profile was completed with the SM as the primary care provider instead of the SS's father and did not document the SM's housing and financial struggles in the assessment.

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

Issue:

Case record contains information that is relevant, useful, factual and objective

Summary:

Another adult resided with the SS and his father. The adult cousin's information and demographics were never collected or added in CONNECTIONS; therefore, pertinent information such as his actual name, birthdate, and CPS history was inaccurately recorded in the case record of this investigation. Additionally, the adult was not notified or interviewed.

Legal Reference:

18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:

MCDHS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The RAP was scored that the SM did not have any housing or financial struggles; despite these being the reasons that she did not have the SS in her care. Additionally, the SS's BF should have been listed as the primary care provider because he was the subject of the report.

Legal Reference:

18 NYCRR 432.2(d)

Action:

MCDHS will accurately reflect the current caretakers of children in risk assessments and accurately assess and document each respective risk element identified into the Risk Assessment Profile.

[redacted]

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

The following investigation were all unsubstantiated.

An Investigation was opened from 8/12/21-11/26/21 with concerns for IG, LS, IF/C/S, and XCP regarding the then 7yo SSs against the SM.

An Investigation was opened from 5/10/21-8/18/21 with concerns for IG and XCP regarding then then 7yo SSs against his BF.

An Investigation was opened from 2/25/21-4/7/21 with concerns for PD/AM regarding the then 9 and 7yo SSs against the SM.

An Investigation was opened from 12/29/20-1/29/21 with concerns for IG, IF/C/S, and L/B/W regarding the then 8 and 7yo SSs against the SM.

An Investigation was opened from 6/5/19-2/19/20 with concerns for IG, IF/C/S and PD/AM regarding the then 7 and 5yo SSs and for EdN regarding the then 7yo SS against the SM.

An Investigation was opened from 2/20/18-11/1/18 with concerns for IG, LMC, and PD/AM against the SM regarding the

then 5 and 4yo SSs.

An Investigation was opened from 9/19/17-10/26/17 due to concerns for the then 4yo SS's BF sexually abusing the then 5yo SS.

A FAR case opened from 1/30/17-3/30/17 due to concerns for IG, IF/C/S, and PD/AM against the SM regarding the then 4 and 3yo SSs.

Preventive Services History

A Preventive Service Case was opened from 7/1/19-7/2/19 for a payment to be made.

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