Child Fatality Report

Report Identification Number: SV-25-011

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

Issue Date: Jun 09, 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 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	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: Nassau
Gender: Female
Date of Death: 03/07/2025
Initial Date OCFS Notified: 03/07/2025

Presenting Information

On 3/7/25, an initial SCR report was received which alleged the father found the 2-month-old subject child choking and called 911. EMS arrived and transported the subject child to the hospital. During transport, the subject child went into cardiac arrest. At around 4:00PM, the subject child arrived at the hospital where medical personnel performed life-saving measures unsuccessfully. The subject child was pronounced deceased at 4:25PM.

On 3/10/25, a subsequent report was received which alleged that on 3/7/25, the father was holding the subject child on his lap when she rolled onto the floor landing face down. The mother picked up the subject child, and the parents tried to soothe her and gave her a bottle. While she was crying the parents wiped an unknown liquid from her mouth. The subject child became unresponsive and the parents attempted CPR and called 911. EMS arrived and transported the subject child to the hospital where she was pronounced deceased. On 3/8/25, an autopsy was conducted which found the subject child had sustained significant injuries including a subarachnoid hemorrhage, multiple abrasions on the head, an internal cervical fracture and hemorrhage of the surrounding soft tissue, and multiple new and healing rib fractures. The caregivers had no explanation for the injuries.

Executive Summary

This fatality report concerns the death of the 2-month-old female subject child. The Nassau County Department of Social Services (NCDSS) received an initial SCR report regarding the subject child's death on 3/7/25, which contained allegations of Inadequate Guardianship and DOA/Fatality against the father. On 3/10/25, a subsequent report was received with allegations of Fractures, Lacerations/Bruises/Welts, Internal Injuries, Inadequate Guardianship, and DOA/Fatality against the mother and father. At the time of the child's death, she resided with the mother, father, and 1-year-old surviving sibling.

On 3/7/25, 911 was contacted due to the subject child reportedly choking. EMS responded and transported the subject child to the hospital, during which the subject child went into cardiac arrest. The child was transported to another hospital that had a Pediatric Intensive Care Unit. During transport, the subject child's pulse became weaker and was lost upon arrival at the second hospital. The subject child was unable to be resuscitated and was pronounced deceased at 4:25PM. There were no foreign bodies found in the child's airways.

On 3/10/25, an autopsy was completed, and the final cause and manner of death were pending at the time the CPS investigation closed. The medical examiner provided preliminary autopsy findings which revealed significant injuries that were consistent with Shaken Baby Syndrome. Law enforcement questioned the father several times regarding the fatal incident. On 3/12/25, the father was arrested after he made admissions of harming the subject child. On 4/10/25, the father was indicted for murder in the second degree.

NCDSS conducted several home visits and interviewed relevant collateral contacts. The surviving sibling was assessed as safe with a maternal uncle; however, after the preliminary autopsy results were received, an emergency removal was conducted and the surviving sibling was placed in foster care. On 3/13/25, NCDSS filed a petition in Family Court and a temporary order of supervision was granted and the surviving sibling remained in foster care. On 4/15/25, a maternal aunt was granted custody of the surviving sibling.

NCDSS conducted a thorough investigation and the case record contained detailed documentation of interviews. Allegations were appropriately substantiated against the father; however, the case record did not contain evidence that supported the findings of Fractures or Internal Injuries against the mother. There was no evidence the mother caused internal injuries or fractures to the subject child, and she was not present for the fatal incident. The Investigation Conclusion contained a summary of case events and lacked explanation for the substantiated/unsubstantiated allegations.

The mother and father were offered bereavement services and funeral assistance as well as referrals for needs identified during the investigation. The subject father received mental health treatment in jail where he was detained throughout the investigation. The mother was cooperative with recommended services. A Family Services Stage remained open due to court-ordered supervision.

PIP Requirement

This review resulted in a citation related to casework practice. In response, NCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the NCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, NCDSS will review the plan(s) 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

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:
There were adequate casework contacts conducted during the investigation and documentation was detailed. Allegations were substantiated against the mother despite a lack of evidence present in the case record to support the findings. The investigation conclusion contained a summary of case events and lacked explanation for the substantiated/unsubstantiated allegations.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	NCDSS substantiated allegations of Internal Injuries and Fractures against the mother; however, the case record does not contain evidence to support the allegations. The father admitted to causing the injuries to the subject child and the mother was not present during the incident.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	NCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Westchester Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/07/2025 **Time of Death:** 04:25 PM

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

County where fatality incident occurred: Nassau
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? Unknown
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	20 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)

LDSS Response

On 3/7/24, NCDSS received the SCR report regarding the death of the SC. NCDSS initiated their investigation within 24 hours, coordinated efforts with LE, contacted the source of the report, conducted a CPS history check on the family, and conducted a face-to-face visit with the SM and SF in the hospital. The 1-year-old SS stayed with a maternal uncle temporarily while the parents were at the hospital before returning to the mother and father's care. The Administration for Children's Services (ACS) was assigned a secondary role and assessed the SS as safe with the maternal uncle.

The ME reported the SC had abrasions on her eyes and face, scrapes that appeared to be irregular, hemorrhaging on the upper lip, internal hemorrhages including lower neck anterior and posterior, a displaced fracture of the neck, healing rib fractures on the left side, hemorrhages in the left chest, bleeding on the inferior and posterior sides of the brain, and an acute right side fracture with bleeding. The ME noted these injuries were not caused by CPR, and were consistent with Shaken Baby Syndrome. On 3/10/25, the SM and SF consented to the removal of the SS and NCDSS filed a neglect petition in Family Court.

The SF was arrested on 3/12/25, and NCDSS interviewed him in jail. The SF stated he was depressed and hearing voices when the incident occurred. On 3/7/25, the SF stated he was tired, and when the SM left him with the SC and SS he “lost it.” The SF stated he did not know what he was doing when he was doing it until it was too late. The SF took the SC from the crib and punched her in the head, stomach, ribs on both sides, the face, and shook her a few times before he threw her. When he realized what he was doing, the SF asked himself, “Is my baby okay?” He observed the SC was having a hard time breathing, so he went to another tenant’s room and asked for help. The SF stated he had a hard time remembering everything, and feels he was “not in his senses” when he caused the SC harm. The SF was uncertain if the physical harm he inflicted on the SC caused her death; however, he believed it did. The SF denied he caused the healing rib fractures and stated he had never hurt the SC before the day of the fatal incident. The SF denied having any concerns regarding the SM’s care for the children. The SF stated he had doubts the SC was his, and when he and the BM would argue she would taunt him, saying the SC was not. The SF stated when the incident occurred, he was suffering from depression, anger issues, his nerves, financial stress, and he was overwhelmed.

NCDSS received information from LE regarding their interview with the SF. The SF initially maintained his original account of what happened to the SC; however, he eventually admitted he slapped, punched, shook, threw the SC on the bed, and put pressure on her chest and torso area with both fists. The SF stated he was stressed due to the children crying, not leaving the home, not working, and the SC potentially not being his biological child. The SF “did not mean for it to go as far as it did,” and stated he gets nervous and forgets things, and due to the possibility of the SC not being his, he did not love her as much.

NCDSS interviewed the SM who denied seeing the SF harm the children, though shared an incident when the SC was approximately 25 days old where the SF threw the SC on the bed. The SM stated the SC did not cry or appear hurt from the incident, and the SM confronted the SF and told him to never do that again. The SM stated at times the SC would cry

more than usual when bathed and clothed, but the SF stated it was because the SC always wanted to be held. The SM stated the SF never seemed to bond with the SC and he treated the SS differently. The SM admitted that during arguments she would sometimes tell the SF that the SC was not his child; however, she confirmed the SC was the SF's biological child. The SM stated the SF always "seemed to suffer from his nerves," easily lost control of his anger, and on one occasion, he pushed the SM.

NCDSS contacted relevant collateral sources including family members, the pediatrician, hospital staff, and LE. Bereavement services were offered to the SM and SF, and the SF reported he received mental health treatment in jail. The SM was willing to engage in recommended services. A maternal aunt was awarded custody of the SS and a case remained open for services when the CPS investigation closed.

Official Manner and Cause of Death

Official Manner: Pending

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)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes

Comments: The fatality was referred to a Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070558 - Deceased Child, Female, 2 Month(s)	070560 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
070558 - Deceased Child, Female, 2 Month(s)	070561 - Father, Male, 20 Year(s)	Inadequate Guardianship	Substantiated
070558 - Deceased Child, Female, 2 Month(s)	070561 - Father, Male, 20 Year(s)	DOA / Fatality	Substantiated
070558 - Deceased Child, Female, 2 Month(s)	070561 - Father, Male, 20 Year(s)	Fractures	Substantiated
070558 - Deceased Child, Female, 2 Month(s)	070561 - Father, Male, 20 Year(s)	Internal Injuries	Substantiated
070558 - Deceased Child, Female, 2 Month(s)	070561 - Father, Male, 20 Year(s)	Lacerations / Bruises / Welts	Substantiated
070558 - Deceased Child, Female, 2 Month(s)	070560 - Mother, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
070558 - Deceased Child, Female, 2 Month(s)	070560 - Mother, Female, 20 Year(s)	Fractures	Substantiated

070558 - Deceased Child, Female, 2 Month(s)	070560 - Mother, Female, 20 Year(s)	Internal Injuries	Substantiated
070558 - Deceased Child, Female, 2 Month(s)	070560 - Mother, Female, 20 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
070559 - Sibling, Male, 1 Year(s)	070560 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
070559 - Sibling, Male, 1 Year(s)	070561 - Father, Male, 20 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?	☒	☐	☐	☐

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:
Bereavement referrals were offered to the mother and father. The mother was provided with additional referrals for identified needs.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
NCDSS conducted a removal after the preliminary autopsy report revealed inflicted injuries to the subject child. A petition was filed in Family Court, and the surviving sibling remained in foster care until 4/15/25, when a maternal aunt was awarded custody.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☒Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	070561 Father Male 20 Year(s)	
Comments:	NCDSS filed a neglect petition against the SF regarding the SS. The initial appearance was held on 3/13/25, the SF was not present due to his arrest on 3/12/25. The case was adjourned until 3/27/25, with an order to produce issued.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
	There was not a fact finding	Care/Custody to Local Social Services District
Respondent:	070560 Mother Female 20 Year(s)	
Comments:	NCDSS filed a neglect petition against the SM regarding the SS. The initial appearance was held on 3/13/25, the SS remained in the custody of NCDSS and an order of supervision was issued. The SM was granted supervised parenting time with the SS and NCDSS was to provide the SM with referrals for parenting, anger management, and a mental health evaluation.	

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
04/10/2025	The subject father	Unknown	Pending
Comments:	On 4/10/25, the subject father was indicted for the murder of the 2-month-old subject child.		

Have any Orders of Protection been issued? Yes	
From: 03/13/2025	**To:** Unknown
Explain: A temporary order of protection was granted in family court against the SM protecting the SS with the exception of supervised visitation at the discretion of NCDSS. A temporary order of protection was issued against the SF protecting the SS.	

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	☒	☐	☐	☐	☐	☐

Other, specify: Anger Management

Additional information, if necessary:
Bereavement counseling was offered to both parents prior to the SF's arrest. Additional referrals were provided to the mother for services required under court-ordered supervision.

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 surviving sibling received services while in foster care.

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:
Services were offered to the mother and father in response to the fatality.

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? No

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

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

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

Known CPS History Outside of NYS

There was no known CPS history outside of 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