Child Fatality Report

Report Identification Number: NY-23-017

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

Issue Date: Jul 18, 2023

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: 27 day(s)
Jurisdiction: New York
Gender: Male
Date of Death: 02/09/2023
Initial Date OCFS Notified: 02/09/2023

Presenting Information

On 2/9/23, the legal guardian, the legal guardian's spouse and the legal guardian's 20-year-old child noticed the 27-day-old male subject child was not breathing while the family was shopping at the grocery store. The family brought the child to the hospital where he was pronounced deceased at 7:24 PM. The child was otherwise healthy and the family members did not have an explanation for his death.

Executive Summary

This fatality report is regarding the death of the 27-day-old male subject child that died on 2/9/23. The child was placed in the custody of his adult sibling by family court via an Article 1017 Direct Placement. At the time of his death, the child resided with his adult sibling as his legal guardian, the legal guardian's spouse, the legal guardian and his spouses' four children, ages 20, 13, 10, and 7 years old and the 20-year-old's 5-year-old child. The surviving children were assessed to be safe in their parents' care.

The Administration for Children's Services (ACS) received the SCR report regarding the death and immediately initiated their investigation. It was learned that the subject child was hospitalized following his birth to receive treatment for a medical condition. ACS filed neglect petitions against the parents due to unaddressed concerns that led to four of the mother's prior children being removed from her care and subsequently freed for adoption. On 1/31/23, the child was placed by family court with the legal guardian via an Article 1017 Direct Placement and discharged to his care on 2/1/23.

On the day of the death, the child was home with the legal guardian and the legal guardian's 20-year-old child. The biological parents visited with the child at the home under the supervision of the legal guardian and the 20-year-old. The parents visited for a couple of hours and the legal guardian and the 20-year-old then took the child to a relative's home to visit. After visiting with the relative, the legal guardian and the 20-year-old took the subject child with them to pick up the 10 and 7-year-old from school and the legal guardian's spouse from work. The 10 and 7-year-old children were dropped off at home and the family proceeded to the store to go shopping with the subject child. The child was in his car seat and placed in the shopping cart. During checkout, the legal guardian's spouse noticed the child did not look well. The child did not appear to be breathing and had a faint pulse. The family ran the child to the car and drove to the hospital. The child was pronounced deceased at the hospital at 7:24 PM.

An autopsy was completed and the final results were not yet available at the time this report was written, as they were pending the results of numerous tests. In speaking with the medical examiner, it was learned there were some findings that were suspicious for injuries to the child's head, but it was unknown when the injuries might have occurred. The medical examiner reported the injuries looked older and could be from birth-related trauma. It was further stated that it did not appear the family did anything that day for the child to die; however, prior to the finalized report he could not rule out anything else or say with certainty there was no neglect of the child. The medical examiner reported that he would make CPS aware of the final findings. Law enforcement investigated the death and observed video footage from the grocery store, which supported the account of events provided by the family. There was no criminality found in regards to the death at the time this report was written.

ACS determined through the information gathered during the investigation and the preliminary autopsy report, the child's death was not indicative of neglect or abuse and there was not a fair preponderance of evidence to substantiate the allegations. The family was provided with assistance for the funeral and bereavement counseling referrals. A child safety

conference was held to discuss the circumstances of the case, and family court intervention was not recommended. The legal guardian and his spouse agreed to voluntary preventive services. The CPS investigation was unfounded and closed on 4/10/23.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to 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?** 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?** Yes

Explain:
An appropriate determination was made given the information gathered throughout the investigation. The CPS investigation was closed and the legal guardian and his spouse agreed to voluntary preventive services.

Was the decision to close the case appropriate? N/A

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

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Although all other casework activity was commensurate with case circumstances, the record did not reflect efforts to locate, notify and interview the fathers of the 5 and 13-year-old children.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	The record did not reflect efforts to notify or interview the fathers of the 5 and 13-year-old children regarding the SCR report.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/09/2023 **Time of Death:** 07:34 PM

Time of fatal incident, if different than time of death: 06:50 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
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	Male	27 Day(s)
Deceased Child's Household	Other Adult - Legal Guardian's wife	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Other Adult - Legal Guardian's Adult Child	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Other Adult - Legal Guardian	Alleged Perpetrator	Male	42 Year(s)
Deceased Child's Household	Other Child - Legal Guardian's Stepchild	No Role	Female	13 Year(s)
Deceased Child's Household	Other Child - Legal Guardian's Child	No Role	Male	9 Year(s)
Deceased Child's Household	Other Child - Legal Guardian's Child	No Role	Female	7 Year(s)
Deceased Child's Household	Other Child - Child of 20-year-old female	No Role	Female	5 Year(s)

LDSS Response

Upon receipt of the SCR report on 2/9/23, ACS initiated their investigation, coordinated efforts with LE, sent notification to the ME and DA, interviewed the family, gathered information from medical collaterals, and assessed the safety of the surviving children.

The legal guardian was interviewed and reported that on the day of the death he woke up at 7:00 AM and the SC was awake. He fed the SC a bottle and a half of formula and laid the SC back down. The SC appeared fine at that time. The legal guardian left the home at 7:40 AM to take his 10 and 7yo children to school and the SC had fallen back to sleep. The legal guardian's adult child stayed home with the SC until the legal guardian returned at 9:00 AM. The SC was still sleeping, looked normal, and was not exhibiting any signs that he was not well. The SC woke up around 10:00 AM. Later in the day the parents came to the home to have a supervised visit with the SC. The parents stayed for 2 hours and when they left the legal guardian, his adult child, and the SC went to the legal guardian's mother's home to visit with her. They stayed for an hour and then left to pick up the legal guardian's spouse from work and the children from school. The legal guardian, his spouse, the legal guardian's adult child and the SC dropped the 10 and 7yo off at home and went to the grocery store around 6:00 PM. The SC was in the car seat placed in the shopping cart and appeared fine. The family finished shopping and while in the checkout line noticed the SC did not look well. The SC did not appear to be breathing and had a faint pulse. They grabbed the SC and ran to the car. The family drove to the hospital and ran the SC into the pediatric emergency department.

ACS interviewed the legal guardian's spouse, who reported the SC was last seen alive around 6:40 PM. The SC was in his car seat in the shopping cart and making noises while he slept. The family discovered the SC was unresponsive between 6:50 and 7:00 PM. The legal guardian's spouse explained that they drove straight to the hospital with the SC strapped in the car seat, running through the traffic lights on the way. The legal guardian's spouse reported the SC did not have any feeding problems; he would stop eating when he was full and burped well afterward; however, on the day of the death the SC would not take his formula. The legal guardian's spouse reported no concerns about the SC's sleeping patterns. The SC had some abnormal breathing when he was initially brought to the guardian's home; however, the abnormal breathing lessened, and he started breathing normally again more recently.

The 13, 10, 7 and 5yo children were interviewed at the home. They denied any concerns for their safety or the care of the SC. The children were not present when the fatal incident occurred. The legal guardian's adult child was interviewed and confirmed she watched the SC during the morning hours. During that time, the SC slept. When she tried to give the SC a bottle he would not drink it. The legal guardian's adult child took videos of the SC during the morning hours, which CPS observed and noted no concerns. The legal guardian's adult child reported when they discovered the SC unresponsive, they drove to the hospital instead of calling 911 because they thought it would be faster.

ACS spoke to the hospital physician, who reported when the SC arrived at the hospital, he was blue, cyanotic, without a pulse, and lifeless. The family did not initiate CPR on their way to the hospital. The doctor reported that not starting CPR earlier can affect a person's ability to regain a pulse; however, the doctor could not say for certain that initiating CPR earlier would have resulted in a different outcome. ACS requested a medical consult, and the result was that without all the test results there was not enough information to consider neglect regarding the death.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063868 - Deceased Child, Male, 27 Days	063890 - Other Adult - Legal Guardian's wife , Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
063868 - Deceased Child, Male, 27 Days	063890 - Other Adult - Legal Guardian's wife , Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
063868 - Deceased Child, Male, 27 Days	063894 - Other Adult - Legal Guardian's Adult Child, Female, 20 Year(s)	DOA / Fatality	Unsubstantiated
063868 - Deceased Child, Male, 27 Days	063894 - Other Adult - Legal Guardian's Adult Child, Female, 20 Year(s)	Inadequate Guardianship	Unsubstantiated
063868 - Deceased Child, Male, 27 Days	063889 - Other Adult - Legal Guardian, Male, 42 Year(s)	DOA / Fatality	Unsubstantiated
063868 - Deceased Child, Male, 27 Days	063889 - Other Adult - Legal Guardian, Male, 42 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐
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	☒	☐	☐	☐

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.

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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs
☐ Used prescription drugs

☐ Used marijuana
☐ 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)
01/17/2023	Deceased Child, Male, 4 Days	Mother, Female, 35 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 4 Days	Mother, Female, 35 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Deceased Child, Male, 4 Days	Father, Male, 61 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged that the mother was diagnosed with bipolar disorder and schizophrenia, and due to this, the mother had episodes of violence. As a result of her mental health conditions, the mother was unable to adequately care for the subject child. The child had not sustained any visible injuries as a result. The role of the father was unknown.

Report Determination: Indicated | **Date of Determination:** 03/18/2023

Basis for Determination:
The allegations against the mother were substantiated, as ACS determined that the mother was homeless, had untreated mental health, and did not have adequate provisions to care for the subject child. ACS added the allegation of IG against the father and substantiated it; however, the investigation conclusion narrative did not address how ACS supported the determination regarding the father.

OCFS Review Results:
ACS initiated the investigation within 24 hours by assessing the safety of the subject child and interviewing the parents. ACS interviewed medical collaterals and gathered pertinent records. ACS determined a removal of the child was necessary and a neglect petition was filed against the parents. The child was placed in foster care. The child's legal guardian was granted Article 1017 direct placement of the child on 1/31/23 against the opposition of ACS. ACS completed a visit to the guardian's home and safe sleep guidance was reviewed in addition to information on the child's medical appointments.

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

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

Between 2017 and 2019, the legal guardian and his spouse had five unfounded CPS investigations, including unsubstantiated allegations of IG, LS, and PD/AM regarding his children.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes

Date the preventive services case was opened: 01/31/2023

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 01/31/2023

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☐	☐	☒	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? ACS documented that while they intended to complete an initial FASP, it was not completed and they could no longer do so because the subject child's involvement on the case was end-dated.				

Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☐	☒	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐

Additional information, if necessary:
While the child was placed in foster care, a foster care agency was involved with the subject child; however, once placed with the legal guardian there was no other agency involved.

Preventive Services History

On 1/31/23, family court placed the child with the legal guardian via an Article 1017 Direct Placement. The child was released from his medical facility to the legal guardian's care on 2/1/23. The neglect petition against the parents was dismissed on 3/7/23 due to the child's death and the parents' services case was closed.

Foster Care Placement History

Following the child's birth, ACS filed Article 10 Neglect Petitions against the parents due to concerns for untreated mental health and the mother's four prior children being removed and eventually freed for adoption. The child was in the custody of ACS between 1/18/23 and 1/31/23; however, remained in a medical facility.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to 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:**
01/18/2023	There was not a fact finding	Withdrawn
Respondent:	051301 Other	
Comments:	The petition was withdrawn due to the death of the child.	

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