Report Identification Number: NY-23-097

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

Issue Date: Mar 18, 2024

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 **Jurisdiction:** Bronx **Date of Death:** 04/02/2023
Age: 5 year(s) **Gender:** Male **Initial Date OCFS Notified:** 10/12/2023

Presenting Information

The New York City Administration for Children's Services (ACS) received a report on 10/12/23, regarding the death of the 5-year-old subject child that occurred on 4/2/23. The report alleged the mother and the mother's partner left Fentanyl and drug paraphernalia, including a spoon and glass pipe, accessible to the child in the mother's bedroom. Sometime between 10:00am and 1:30pm, the child ingested an unknown quantity of Fentanyl. At approximately 1:30pm, the mother found the child unresponsive in his bed. Emergency services were called, and the child was pronounced deceased. The cause of death was acute fentanyl intoxication along with hemorrhagic complications of vascular malformation of the bladder.

Executive Summary

This fatality report concerns the death of a 5-year-old male subject child that occurred on 4/2/23. A report was initially made to the SCR on that same date with allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Medical Care against the mother and the parent substitute (PS). The initial investigation received on 4/2/23 was unsubstantiated for DOA/Fatality due to a lack of credible evidence that the mother and the parent substitute's actions or inactions contributed to the subject child's death. The allegations of Inadequate Guardianship and Lack of Medical Care against the mother and the parent substitute were substantiated as they both were aware of the subject child's medical diagnoses and that the subject child was ill in the days leading up to the death and did not seek medical attention for the subject child. New information was received as a result of the toxicology report, and an SCR report was registered on 10/12/23, regarding the subject child's death. The New York City Administration for Children's Services (ACS) received the report and investigated the subject child's death.

At the time of the subject child's death, he resided with his mother and the parent substitute. The subject child had no contact with his father as there was an order of protection in place. There were no other children that resided in the home. The mother's partner had a 10-year-old child (OC), who resided with her mother and had regular visitation with the parent substitute. ACS assessed the safety of the 10-year-old child and filed an Article 10 Neglect Petition against the parent substitute in family court. The 10-year-old child remained in the care of her mother with ACS supervision and the parent substitute was allowed supervised visitation. The family court case was ongoing at the time this report was written.

The final autopsy report was not received at the time this report was written. ACS spoke with the medical examiner's office and learned the subject child died as a result of acute fentanyl intoxication with hemorrhagic complications of vascular malformation of the bladder. ACS obtained a copy of the revised death certificate. ACS spoke with law enforcement and learned the criminal investigation was ongoing and the death was being considered a homicide. Due to the ongoing criminal investigation, ACS was unable to discuss the new information with the mother and parent substitute. The record did not reflect any arrests were made regarding the death and the criminal investigation remained open at the time this report was written.

ACS gathered information surrounding the fatality from collateral sources which included law enforcement, medical staff, the medical examiner, and relatives. ACS provided the mother, parent substitute, and other child's mother with resources for fatality-related services upon receipt of the initial report; however, it was unknown if the family engaged with any services after the death.

PIP Requirement

For citations identified in historical cases, 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:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
ACS made an appropriate determination based on the evidence obtained throughout the investigation.

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:
Casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/02/2023 **Time of Death:** 04:59 PM

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

County where fatality incident occurred: New York

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? Yes
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	5 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Other - Parent substitute	Alleged Perpetrator	Male	40 Year(s)
Other Household 1	Other Child - Parent substitute's child	Alleged Victim	Female	10 Year(s)

LDSS Response

On 10/12/13, ACS received a report regarding the death of the SC that was previously investigated. ACS initiated their investigation within 24 hours and coordinated efforts with their multidisciplinary team. ACS established there were no surviving siblings residing in the home where the fatal incident occurred; however, the PS had a 10yo child (OC) who resided with her mother and visited the SM and the PS on a regular basis.

ACS spoke with the ME's office on 10/13/23 and learned the SC died of acute fentanyl intoxication along with hemorrhagic complications of vascular malformation of the bladder due to Klippel-Trenaunay Syndrome (KTS). The SC was not prescribed fentanyl by any medical professional, and it would not have been a form of treatment for him outside of a hospital setting. The record reflected the ME reviewed the previous fatality notes from the day of the SC's passing on 4/2/23 and there was drug paraphernalia and two baggies with what appeared to be a white substance observed in the home; however, it was unclear if the substance was taken by LE as evidence or if the substance was tested.

Due to the ongoing criminal investigation, ACS was unable to discuss the new information with the SM and PS. ACS learned from the prior investigation the SC was not receiving medical care for his medical condition and was cared for at home by the SM and PS, and both were aware of the SC's being ill prior to his death. The SM and PS did not seek medical treatment for the SC and reported providing the SC with Pedialyte and an over-the-counter fever reducer. On 11/24/23, the SM was interviewed by LE and made aware of the fentanyl that was found in the SC's body which the ME deemed as the SC's cause of death. The SM had no explanation for the fentanyl in the SC's body. The record did not reflect the PS was interviewed by LE prior to the close of the CPS investigation.

ACS observed and interviewed the OC at school on 10/13/23, 10/24/23, 11/6/23, and 11/20/23. The OC had no information regarding the SC's death. School staff had no concerns for the OC. The OC's mother had no concerns for the PS or the SM and was unaware of any substance use by the SM or the PS. The SC was regularly spending time at the SM

and PS's home. ACS filed an Article 10 Neglect Petition against the PS regarding the OC on 11/24/23, and opened a preventive services case. The OC remained in the care of her mother and the family court case was ongoing at the time this report was written.

ACS substantiated the allegations of DOA/Fatality and Inadequate guardianship against the SM and the PS regarding the SC. ACS determined there was a fair preponderance of evidence the actions of the SM and PS contributed to the death of the SC. The SC was not prescribed fentanyl by any medical provider and was not receiving ongoing medical treatment for his medical condition. The SM and PS were aware the SC was ill in the days leading up to his death and failed to seek medical treatment. The SC was primarily home with the SM and PS, and it was unclear how the SC came into contact with the Fentanyl. ACS substantiated the allegation of Inadequate Guardianship against the SM and PS regarding the OC. ACS determined there was a fair preponderance of evidence that the OC was regularly in the PS's home, and it was unknown if the OC had been exposed to any substances. ACS indicated and closed the CPS investigation, and the preventive services case remained open regarding the PS and the OC.

Official Manner and Cause of Death

Official Manner: Homicide
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
Comments: The investigation adhered to previously approved protocols for joint investigations as ACS coordinated efforts with law enforcement and notified the DA's office of the death.

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066549 - Deceased Child, Male, 5 Year(s)	066550 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
066549 - Deceased Child, Male, 5 Year(s)	066550 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
066549 - Deceased Child, Male, 5 Year(s)	066551 - Other - Parent substitute, Male, 40 Year(s)	DOA / Fatality	Substantiated
066549 - Deceased Child, Male, 5 Year(s)	066551 - Other - Parent substitute, Male, 40 Year(s)	Inadequate Guardianship	Substantiated
066553 - Other Child - Parent substitute's child, Female, 10 Year(s)	066550 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
066553 - Other Child - Parent substitute's child, Female, 10 Year(s)	066551 - Other - Parent substitute, Male, 40 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?	☒	☐	☐	☐

Additional information:

ACS was unable to interview the SM and the PS about the new information regarding the SC's death due to the criminal investigation, and the request from LE and the DA to not speak with the SM and PS.

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:
Following the death, the family was provided with community-based resources for bereavement services and burial assistance; however, it was unknown if the family engaged with services.

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?	☐	☒	☐	☐

Explain as necessary:
There were no other children that resided in the home and the OC had supervised visitation with the PS.

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:**
11/24/2023	There was not a fact finding	There was not a disposition
Respondent:	066551 Other Male 40 Year(s)	
Comments:	On 11/24/23, ACS filed a neglect petition against the parent substitute regarding his 10yo child. As a result of the petition, the 10yo child was released to her mother with ACS supervision. On 12/6/24, the parent substitute was granted supervised visitation, and the parent substitute was court ordered to submit to three random drug screenings prior to the 12/20/23 court date. On 12/20/23, the court ordered the parent substitute take random drug screenings twice per week and supervised visitation continued. On 1/24/24, a continued family court hearing was held, and the parent substitute was granted 30 minutes of unsupervised time for visits twice per week. The parent substitute was referred for a substance abuse evaluation and the next family court proceeding was scheduled for 3/5/24.	

Have any Orders of Protection been issued? No

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
At the time of the death, ACS offered the SM and PS bereavement services and burial assistance and provided the family a list of community-based resources, which the family accepted. It was unknown if the family followed through with the services.

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:
Following the death, ACS provided the OC's mother a list of community-based resources for the OC.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Following the death, ACS offered the SM and PS burial assistance and bereavement services and provided them with a list of community-based resources.

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

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)
04/02/2023	Deceased Child, Male, 5 Years	Mother, Female, 33 Years	DOA / Fatality	Unsubstantiated	Yes
	Deceased Child, Male, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 5 Years	Mother, Female, 33 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 5 Years	Other - Parent substitute, Male, 40 Years	DOA / Fatality	Unsubstantiated	
	Deceased Child, Male, 5 Years	Other - Parent substitute, Male, 40 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 5 Years	Other - Parent substitute, Male, 40 Years	Lack of Medical Care	Substantiated	

Report Summary:
Two SCR reports were received which alleged the SM found the SC unresponsive in his bedroom on 4/2/23. The SM reported the SC was not eating, he was vomiting, and had a fever for a few days prior to his death. The SM did not seek medical treatment for the SC. The night prior to the death, the SM gave the SC Tylenol and Pedialyte and the SC went to sleep in his bed. The PS was woken by the SM yelling something was wrong with the SC. The PS called 911 and was instructed by the dispatcher how to perform CPR on the SC until first responders arrived. EMS arrived and transported the SC to the hospital, where he was pronounced deceased at 4:59pm.

Report Determination: Indicated | **Date of Determination:** 06/01/2023

Basis for Determination:
ACS found a fair preponderance of evidence to support the allegations of IG and LMC against the SM and the PS. ACS determined the SM and the PS were aware the SC was diagnosed with a rare congenital medical condition and in the days leading to the SC’s death he was ill. The SM and the PS failed to seek routine medical care regarding the SC’s medical diagnoses and did not seek medical treatment for the SC while knowing the SC was not feeling well. The SM and PS failed to meet a minimal degree of care for the SC. The allegation of DOA/Fatality was unsubstantiated due to a lack of credible evidence.

OCFS Review Results:
ACS completed case objectives within the required time frames. ACS spoke with family members and relevant collateral sources and provided the family with appropriate fatality related resources. The PS was not listed on the risk assessment profile as a secondary caretaker; although, he was primary caretaker of the SC and his child visited the home on a regular basis. ACS assessed the PS's child as safe with her mother.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
ACS did not identify a secondary caretaker on the RAP. The PS was a regular caretaker for the SC, was a confirmed subject, and his child visited the home on a regular basis. Therefore, the RAP was completed and scored inaccurately.
Legal Reference:
18 NYCRR 432.2(d)
Action:
ACS 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.

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

In 2017, the allegations of IG and PD/AM were substantiated against the mother regarding the SC. The SC tested positive for drugs at birth. ACS filed an Article 10 Neglect petition against the mother. The SC was placed in the care of his father and a services case was opened.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Preventive Services History

ACS opened a services case on 10/6/17. A Neglect petition was filed against the mother on 10/10/17, and the SC was released to the father. On 12/14/17, the SC was released to the mother and father with court ordered supervision. The mother completed her required outpatient substance abuse treatment, parenting classes, and maintained her sobriety. The services case was closed on 8/16/18.

ACS opened a services case on 4/1/19 regarding a court ordered investigation that was received from family court. The mother petitioned for sole legal and physical custody of the SC. ACS made efforts to locate the father but were unsuccessful. The mother was granted sole custody of the SC and the services case was closed on 5/8/19.

ACS opened a services case on 11/12/21, regarding a court ordered investigation that was received from family court. The father filed for visitation and custody of the SC against the mother. ACS conducted interviews, home visits, and spoke with collateral contacts. There were 3 active orders of protection against the father, protecting the mother and the child until 2022, 2024, and 2029. The report was sent to family court and the services case was closed on 12/21/21. The SC remained in the custody of the mother.

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

Have any Orders of Protection been issued? Yes	
From: 11/12/2021	**To:** Unknown

Explain:
The record reflected there was a full stay away order of protection issued against the father regarding the subject child that was in effect until 2024, and there was a full stay away order of protection against the father regarding the mother in effect until 2029.

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