Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-111

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

Issue Date: Mar 29, 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
Age: 2 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 11/10/2023
Initial Date OCFS Notified: 11/11/2023

Presenting Information

An SCR report received on 11/11/23 alleged on 11/10/23, the father was caring for the subject child at home for most of the day. At 8:00PM, the mother arrived home and checked on the child. It was unknown what objects were in the crib, or in what position the child was lying. The father then left the home. At 11:00PM, the mother checked on the child again and he was unresponsive. The mother called 911 and emergency medical services (EMS) responded. EMS administered cardiopulmonary resuscitation (CPR) and epinephrine. EMS transported the child to the hospital, arrived at 11:30PM, and the child was pronounced deceased at 11:46PM. The child was otherwise healthy, and the parents did not have an explanation for the death. An additional SCR report was received on the same day with substantively similar allegations.

Executive Summary

This report concerns the death of the 2-month-old subject child. The Administration for Children's Services (ACS) received two SCR reports regarding the child's death on 11/11/23. At the time of the child's death, he resided with his mother and father. A sibling to the child had died in April 2023, and that death was previously investigated by ACS. The father had additional history separate from the mother regarding other children no longer in his care.

The parents described a schedule in which they shared caretaking roles in "shifts." There were discrepancies in reported feeding times that were not clarified to gather a complete picture of the days leading up to the child's death. The morning of 11/10/23, the father stated he fed the child a bottle at 5:30/6:00AM; however, the mother reported she provided the bottle at 5:00AM, as the father was not home. The father referred to the mother feeding the child again prior to leaving the house for the day, around 11:00AM; however, the mother stated at 10:00AM, she observed the child and father both sleeping and that she left the home between 11:00AM/12:00PM without again checking on the child. It was not confirmed if an 11:00AM feeding occurred. The father was home with the child and said the child's next bottle was given at 4:30PM and then the child slept until about 8:30PM. The mother had returned home at 8:00PM and the father informed the mother the child had diarrhea; an issue that began the day prior. The mother did not recall checking on the child upon returning home; however, the father reported they did, and the child was observed moving in his crib. The father left the home at 8:30PM. At 11:03PM, the mother realized she had not checked on the child and found him unresponsive in his crib at that time. The mother called 911 and was instructed by dispatch to administer CPR until EMS arrived. The child was transported to the hospital, where he was pronounced deceased at 11:46PM.

The medical examiner was notified and performed an autopsy. The cause and manner of death were pending at the time the CPS investigation was closed; however, the final autopsy was available at the time this report was written. The cause and manner of death were undetermined. The report noted there was no significant internal trauma noted to the child, though there were minor abrasions to the chin, cheek, and right ear. The child was noted to be small for his age and was less than 1st percentile for height and weight at birth and at death. The deceased sibling's autopsy, which had not been available at the time of the previous investigation, but which was available during this investigation, indicated the sibling's cause of death was Sudden Death in an Infant with Microcephaly and Failure to Thrive of Undetermined Etiology. The medical examiner to the subject child confirmed communication with the medical examiner to the sibling, due to the similarities in the deaths. Law enforcement's investigation remained ongoing pending autopsy results. The record did not reflect the subject child's reportedly limited feeding schedule was discussed with the current medical examiner.

ACS substantiated the allegation of Inadequate Guardianship against the mother and father, citing the parents' failure to follow safe sleep guidance in that the child was known to be placed to sleep on his stomach, with multiple items in his bassinet. The parents were provided a specific feeding schedule for the child by his pediatrician due to weight gain concerns and chose not to follow the plan; however, the allegation of Lack of Medical Care was not added or substantiated despite the parents' failure to follow the prescribed treatment plan. ACS cited the pending status of the autopsy report when unsubstantiating the allegation of DOA/Fatality against the parents.

The parents declined bereavement services offered by ACS.

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:**
    - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Safety Assessments were not required as there were no surviving siblings in the home. Additional allegations of Lack of Medical Care were evident; however, not considered.

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 has detail of the consultation.

Explain:
The deceased sibling's autopsy was available at the time of this investigation, and it was confirmed both MEs assigned to the sibling and subject child were in communication with one another due to the similarities of circumstances surrounding both deaths. Neither offered additional comments on the death's at the time of the open investigation due to the pending autopsy of the subject child.

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:	The parents failed to follow the prescribed treatment plan (feeding schedule), despite awareness of the child's condition (history of low weight); however, the allegation of Lack of Medical Care was not added/substantiated.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS 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.
Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Conversation with the parents were lacking potentially key related questions. Given the historical death, it was important to determine the subject child's feeding contents and schedule, and this was not adequately clarified with the parents.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/10/2023 **Time of Death:** 11:46 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: 11:05 PM
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	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)

LDSS Response

On 11/11/23, ACS received two reports regarding the death of the subject child. ACS initiated their investigation timely and contacted the sources of the reports; however, the source of the duplicate report did not respond.

During interviews, neither parent presented a clear and concise account, which led to a convoluted timeline. The mother reported on 11/8/23, the child had a doctor's appointment and was found to be underweight. The doctor wrote out a feeding schedule, which was shown to ACS, and a follow-up appointment was scheduled. On 11/9/23, the child woke up at 5:00AM and the mother stated the father fed the child, though the father said the mother fed the child. At 8:00AM, the child cried, and the mother burped the child, but did not state whether the child was fed at that time. At 10:35AM, the mother woke up and noted the child and father were both asleep. At noon, the mother left the home. The father stated the mother would feed the child prior to leaving, though the mother was not asked if a feeding was provided that morning. The father was then home with the child, and stated the next feedings were 4:30-5:00PM and 8-9:00PM; however, then stated the child had a bowel movement at 2:00PM and did not eat again until 8:00PM. The father noted the child had diarrhea and had vomited during the day. The record was unclear if a bottle was provided between 5:00AM and 8:00PM on 11/9/23. The mother returned home, and the child ate between 8-9:00PM and vomited again. The father left the home sometime before 10:00PM and was out the remainder of the night. The child woke around 2:30AM on 11/10/23, crying for the bottle. The mother was asked if she changed the child's diaper; however, was not asked if a bottle was provided. The child next woke up at 5:00AM, and the mother stated she fed him a bottle and changed his diaper. The mother reported the father was not home at that time; however, the father stated he provided the bottle at 5:30AM. The mother then left the home between 11:00AM/12:00PM and stated she had not checked on the child prior to leaving, although the father stated the mother fed the child prior to leaving at 11:00AM. The father was home with the child and stated he had to change the child's diaper often because the child had diarrhea. The parents were not asked if medical recommendations were sought due to the vomit and diarrhea. The father next fed the child at 4:30PM. The record was unclear if a bottle had in fact been provided between 5:00AM and 4:30PM. The father reported the child went to sleep. The mother returned at 8:00PM but did not check on the child at that time; however, reported the father had, and the father reported he had seen the child move in his crib prior to leaving the home at 8:30PM. The mother next checked on the child at 11:03PM and found him unresponsive.

The parents were asked about their knowledge of safe sleep recommendations. The father stated he was aware; however, he had his own method. The mother did not respond, but hospital records indicated she was provided with the information. The child was found to be sleeping on his stomach, with a teddy bear, pillow, and blankets. The ME expressed concern over the number of objects in the bassinet.

ACS spoke with the pediatrician, who would only confirm dates of appointments. It was confirmed the child was brought to all his appointments, including 11/8/23. Records were requested; however, did not detail the 11/8/23 appointment. Hospital records obtained referenced the mother breast feeding the child and skipping some night feedings. The pediatrician's feeding schedule referenced formula feeding. This discrepancy was not clarified, nor were the parents asked what, if any, additional contents were added to the bottle, as this was a practice noted in the prior fatality. Furthermore, the parents were not asked how much formula or breast milk was provided in the bottle, and what the feeding schedule was prior to the doctor's recommendations.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or 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: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066632 - Deceased Child, Male, 2 Month(s)	066636 - Mother, Female, 30 Year(s)	DOA / Fatality	Unsubstantiated
066632 - Deceased Child, Male, 2 Month(s)	066636 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
066632 - Deceased Child, Male, 2 Month(s)	066637 - Father, Male, 35 Year(s)	DOA / Fatality	Unsubstantiated
066632 - Deceased Child, Male, 2 Month(s)	066637 - Father, Male, 35 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:

The parents were offered and declined burial assistance and bereavement resources.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/16/2023	Sibling, Male, 9 Months	Mother, Female, 30 Years	DOA / Fatality	Unsubstantiated	Yes
	Sibling, Male, 9 Months	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 9 Months	Mother, Female, 30 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 9 Months	Father, Male, 35 Years	DOA / Fatality	Unsubstantiated	
	Sibling, Male, 9 Months	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 9 Months	Father, Male, 35 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
Two SCR reports alleged on 4/15/23, at 9:00PM, the mother put the sibling in his crib for the night. The morning of 4/16/23, around 5:30AM, the father checked on the sibling, and he was fine at that time. The mother then woke around 2:30PM and checked on the sibling in his crib. The mother found the sibling unresponsive. The mother called 911 and the father attempted CPR. Emergency medical services arrived at the home; however, the sibling was already deceased. The sibling was otherwise healthy, and the parents did not have an explanation for his death. Additionally, the sibling had

a healing wound on his chin, and an abrasion on his face which the parents were unable to explain.

Report Determination: Unfounded | **Date of Determination:** 06/13/2023

Basis for Determination:
DOA/Fatality was unsubstantiated based on the mother contacting the police upon finding the sibling unresponsive and that the father attempted CPR and the sibling was alive the last time the father saw him. Inadequate Guardianship was unsubstantiated as provisions for the sibling were observed, the sibling had a crib, and the mother was aware of safe sleep recommendations. Lacerations/Bruises/Welts was unsubstantiated because the mother took the sibling to the doctor when the mark on his chin was small, and the mother said the abrasion was due to rubbing his face on the Pack 'n Play netting. The father said the abrasion was due to the bottle being too warm when he fed the sibling.

OCFS Review Results:
Insufficient information was gathered throughout the investigation. The parents described a rigid feeding schedule that consisted of mixing contents other than formula into a bottle. This practice was not discussed with the ME or pediatrician and a well-child visit was not confirmed. Interviews implied the sibling had not received a bottle within 16 hours of his death. The father described a routine in which the sibling was in a crib most of the day; physical or developmental harm to the sibling was not explored. Despite the father's history of being unable to meet a child's basic needs, the parents were not referred to services to prepare for the impending arrival of the subject child.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
The allegation of IG was pre-determined. Collateral contact with the sibling's pediatrician could have provided further information; however, the case was closed prior to successful contact. The ME was not asked for an overall physical assessment of the sibling. The rigid feeding and sleep schedule developed by the father was not discussed with relevant collaterals in order to assess harm.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACS will continue to work on this issue and revise their current PIP if deemed necessary.

Issue:
Failure to provide safe sleep education/information

Summary:
A progress note noted that safe sleep information was not provided as there was no child under the age of 1 in the home; however, it was known the mother was pregnant (with the current subject child) at that time.

Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:
There is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS. ACS will continue to work on this issue and revise their current PIP if deemed necessary.

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

The father had additional history with ACS, separate from the mother.

In 2/2015, the allegation of Inadequate Guardianship was substantiated against the father regarding his then 1-day-old female child. This child was removed as neither the father nor this child's mother were able to provide adequate

supervision or meet her basic needs. The record noted the father was diagnosed with an intellectual disability.

In 4/2016, the allegation of Inadequate Guardianship was substantiated against the father regarding his then 1-day-old male child. That child's sibling, previously removed in 2015, remained in foster care. The record noted the father and that child's mother had diagnoses of intellectual disabilities. It was determined neither parent could provide adequate supervision for the 1-day-old without the intervention of court ordered services, which included preventive and home making services. Subsequent allegations of Inadequate Guardianship against the father made in 11/2016 were unsubstantiated as the father was not a caretaker to that child at the time of the report. He had supervised visitation, which was not being utilized. That child was removed in 11/2016.

During this investigation, ACS learned of an additional child the father stated was his, although the historical record did not reflect the relationship was confirmed. That child was freed for adoption.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Foster Care Placement History

The father's two additional confirmed children were removed shortly after their births, in 2015 and 2016. The record reflected the reason for the placement of the two other children was due to the father and those children's mother having untreated mental health and domestic violence in the household. It was noted the father had cognitive delays which impacted his ability to care for the children. The father's service plan included engaging in mental health treatment, specifically dyadic therapy. The father had supervised visitation. The father stopped visiting with the children in 11/2018, made minimal to no progress in service plan goals, and permanency for both children was ultimately obtained through KinGAP in 4/2019.

An additional child the father named was placed in foster care shortly after his birth in 2009 and subsequently adopted. The father did not have a role in that child's foster care case.

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