Child Fatality Report

Report Identification Number: NY-22-007

Prepared by: New York City Regional Office

Issue Date: Aug 03, 2022

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 has an open 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		
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	
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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 02/03/2022
Initial Date OCFS Notified: 02/03/2022

Presenting Information

The 2/3/22 SCR report alleged the SC was in the care and custody of her MGM for unknown reasons. The report further alleged on 2/3/22, at an unknown time, the SC was found unresponsive by the MGM or an unknown cousin who was at the residence. The cousin initiated chest compressions and EMS was contacted. The SC was transported to the hospital by EMS and LE. The SC arrived at the hospital at 7:27 AM and was pronounced dead at 8:00 AM. The MGM had no explanation as to the SC's demise.

Executive Summary

The 5-month-old female child (SC) died on 2/3/22. As of 7/13/22, NYCRO had not received a copy of the ME's report.

The allegations of the 2/3/22 reports were DOA/Fatality and IG of the SC by the MA, maternal cousin (MC), and maternal great grandmother (MGGM). The BM and BF were listed as having no role.

At the time of the fatality, the SC was residing with her adult MC, MA, and MGGM. There were no surviving siblings or other children in the household.

According to the MA, on 2/2/22, she assisted the MC in bringing the SC to her service provider program appointment with the parents. The SC acted normal, and everything was well. The MA said when she, the SC, and MC arrived home, the SC was fed, and the MA then placed the SC in her portable crib as everyone in the home took a nap. The SC awoke and the MC attended to the SC. The SC had her last formula at 10:00PM went to sleep at 11:30PM. The MA awoke between 5:00AM-5:15AM on 2/3/22 and prepared for work. At the time the SC was crying. The MA said she did not check on the SC. The MA said when she left home she received a call from the MC indicating the SC was "limp". The MA said she told the MC to call 911. LE first arrived at the home, followed by the FDNY, and then EMS. LE performed CPR until EMS arrived and transported the SC to the hospital where she was pronounced dead.

On 2/4/22, the ME informed ACS the cause and manner of death were pending further studies. There were no new injuries on the SC. The old fractures to the ribs and arm had nothing to do with the SC's death. The ME opined that the way the SC was placed to sleep was the cause of death.

On 4/20/22, ACS substantiated the allegations of DOA/Fatality and IG of the SC by the MA and MC. ACS documented the SC was placed on her stomach to sleep and on the morning of 2/3/22, the MA heard the SC crying around 5:00 AM but did not check the SC. The MC then awoke to prepare the SC's bottle, and found the SC unresponsive. ACS documented the MA and MC were aware of the unsafe sleep position for the infant. ACS unsubstantiated the allegations of DOA/Fatality and IG by the MGGM.

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:
There was sufficient information gathered to make determination for all allegations including those on the intake report.

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 no surviving siblings or other children in the home.

Required Actions Related to the Fatality

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

Issue:	Adequacy of services following the fatality
Summary:	The documentation did not reflect the MA, MC, or the MGGM were offered services related to the fatality.
Legal Reference:	18 NYCRR 432.2(b)(4);428.6
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/03/2022 **Time of Death:** 08:00 AM (Approximate)

Time of fatal incident, if different than time of death: 07:00 AM

County where fatality incident occurred: Kings

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 alcohol or drugs? N/A
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes

At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☒ Asleep ☐ 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	5 Month(s)
Deceased Child's Household	Foster Parent	Alleged Perpetrator	Female	50 Year(s)
Deceased Child's Household	Other Adult - Maternal Great Grandmother	Alleged Perpetrator	Female	83 Year(s)
Deceased Child's Household	Other Adult - cousin	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Mother	No Role	Female	23 Year(s)

LDSS Response

On 2/3/22, medical personnel told ACS when EMS arrived at the home, the SC was limp. The MC called 911. When EMS arrived, CPR was initiated and was ongoing until the SC arrived at the hospital. No pulse was found; however, there was no trauma found and the SC was free of visible marks and bruises.

The primary care physician (PCP) said the SC was seen on 12/13/21. The SC was healthy.

On 2/3/22, the SC's medical specialist stated the SC had a medical condition which was not life threatening. The medical specialist had no medical concerns.

On 2/3/22, the MA was interviewed and she denied the SC co-slept with anyone. The MA explained that when she was at work, the MC and MGGM cared for the SC. When she returned home, everyone contributed to the SC's supervision. The MA said she, MC, and MGGM did not engage in substance abuse.

On 2/3/22, the MC reported that on 2/2/22, she, the MA, and the SC left to attend a service provider program appointment with the BM and BF. The SC was fed prior to leaving the home. They arrived at the program about two hours later and the SC was fine. Once the appointment was completed, they left and arrived home around 3:00 PM. The SC was put to sleep for a nap by the MA around 5:00PM as she did not wake until 9:00PM. The MA fed the SC around 10:00PM and then put the SC to sleep at 11:30PM. The MC said she awoke at 6:45AM to prepare the SC's breakfast. When she finished preparing the bottle, she went to wake the SC; however, the SC did not respond. The MC said she picked up the SC and saw that the SC was limp and warm. The MC said she placed the SC on her bed, on her back, and started to perform CPR. The SC did not respond and at that time she ran to wake up the MGGM. She and the MGGM walked back into the bedroom, as she then called the MA. The MA told her to call 911 which she did. The LE, FDNY, and EMS arrived at the home. EMS took over and performed CPR. The MC denied substance use.

On 2/3/22, the MGGM stated she was awakened by the MC regarding the SC not responding. She said she walked into the SC's bedroom and saw the SC on her back on the MC's bed; the MC was performing CPR. She then picked up the SC and the SC was not responding. The MC then called 911 and LE, FDNY, and EMS arrived. EMS transported the SC to the hospital. She said when the MA was at work, she, and the MC cared for the SC. The MA and MC took care of the SC most of the time. She had no concerns regarding the SC's health and behavior leading up to 2/3/22. The MGGM said she did not engage in substance use.

On 2/3/22, the BM informed ACS that her attorney told her not to speak with ACS. ACS also attempted to contact the BF but was not successful.

On 2/4/22, LE said the final cause of the SC's passing may not be for another three months as many tests were taken and the results were pending. LE stated that currently, the cause of death was "undetermined." The SC's old injuries were not reported to be in correlation with her death. LE indicated their investigation did not point to any criminality.

On 2/4/22, a neighbor said he did not have any safety concerns for the family. He indicated that the family was a "nice family," as they had never caused any problems.

On 4/2/22, ACS spoke with the service provider regarding the family and services and learned the BM, BF, and SC arrived to the agency on 2/2/22 for intake only. They were escorted by the MA. The SC appeared alert and playful.

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: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

060678 - Deceased Child, Female, 5 Mons	060807 - Other Adult - Maternal Great Grandmother, Female, 83 Year(s)	DOA / Fatality	Unsubstantiated
060678 - Deceased Child, Female, 5 Mons	060807 - Other Adult - Maternal Great Grandmother, Female, 83 Year(s)	Inadequate Guardianship	Unsubstantiated
060678 - Deceased Child, Female, 5 Mons	060808 - Foster Parent, Female, 50 Year(s)	DOA / Fatality	Substantiated
060678 - Deceased Child, Female, 5 Mons	060808 - Foster Parent, Female, 50 Year(s)	Inadequate Guardianship	Substantiated
060678 - Deceased Child, Female, 5 Mons	060809 - Other Adult - cousin, Female, 23 Year(s)	DOA / Fatality	Substantiated
060678 - Deceased Child, Female, 5 Mons	060809 - Other Adult - cousin, Female, 23 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	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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:

The documentation did not reflect family members were interviewed. On 2/3/22, the BM informed ACS that her attorney told her not to speak with ACS.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
On 2/3/22, the BM informed ACS that her attorney told her not to speak with ACS. The notes reflected that the BF did not make himself available to ACS.

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? N/A
Explain:
There were no SSs or other CHN in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Unable to Determine
Explain:
On 2/3/22, the BM informed ACS that her attorney told her not to speak with ACS. The notes reflected that the BF did not make himself available to ACS. According to ACS, after the initial contact with the family regarding the incident, ACS was not able to contact the family. ACS spoke with the service provider regarding the family and services and learned the BM, BF, and SC arrived to the agency on 2/2/22 for intake only.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
Were there any siblings ever placed outside of the home prior to this child's death? N/A
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
☒ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

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)
10/16/2021	Deceased Child, Female, 1 Months	Grandparent, Female, 49 Years	Fractures	Unsubstantiated	No
	Deceased Child, Female, 1 Months	Grandparent, Female, 49 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Months	Grandparent, Female, 49 Years	Internal Injuries	Unsubstantiated	

Deceased Child, Female, 1 Months	Mother, Female, 23 Years	Fractures	Substantiated
Deceased Child, Female, 1 Months	Mother, Female, 23 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 1 Months	Mother, Female, 23 Years	Internal Injuries	Substantiated
Deceased Child, Female, 1 Months	Father, Male, 22 Years	Fractures	Substantiated
Deceased Child, Female, 1 Months	Father, Male, 22 Years	Inadequate Guardianship	Substantiated
Deceased Child, Female, 1 Months	Father, Male, 22 Years	Internal Injuries	Substantiated

Report Summary:
The 10/16/21 report alleged that the SC had a fractured right humerus with no explanation for the injury. The parents were the sole caretakers for the SC.

Report Determination: Indicated | **Date of Determination:** 12/09/2021

Basis for Determination:
ACS substantiated the allegations on the basis of some credible evidence. The child was diagnosed with multiple fractures and the parents had no plausible explanations for the injuries. ACS attributed the injuries to parents actions or inactions given the age of the child, plus the fact that there was no medical reason for the child's injuries.

OCFS Review Results:
The report was initiated in a timely manner and the appropriate notices were provided. ACS relied on the information from medical personnel to assist in making the determination. There was evidence of supervisory review throughout. An Article Ten Abuse petition was considered and appropriately filed. The child was removed and placed with paternal relatives. The child was then placed with maternal relatives and remained with them until her death.

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

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.

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: 10/20/2021

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: 10/20/2021

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? The FASP of 1/18/22 was not approved in a timely manner. The CONNECTIONS system reflected the FASP was not approved until 1/19/22.				
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:
During the 10/16/21 investigation, ACS opened a service case on 10/20/21 as there was a needs for services. The initial FASP reflected the SC was brought to the hospital with 16 rib fractures with multiple fractures in six ribs. The SC also had a fractured right humerus.

Preventive Services History

The Family Service Progress Notes (FSPN) reflected that the Family Court approved the SC's discharge from foster care on 12/1/21. The SC was directly placed with the MA with ACS supervision. The 1/18/22 FASP reflected an Early Intervention referral was submitted on behalf of the SC and a service provider referral was submitted. The BM was referred for clinical health services. The FASP noted safe sleep had been discussed multiple times with all caregivers.

The 1/28/22 FASP reflected the SC was residing with her MA, MGGM, and MC. The SC was remanded originally as the SC was placed with the PGGM and PA. The home study was completed as foster care was being explored. The family then went on vacation outside the United States for one month as the SC was then placed at her current location. The MA, MGGM, and MC did not want foster care for the SC as the SC's status was changed to a release to relative. The FSPN reflected that ACS conducted visits to the home of the MA on 12/7/21, 12/20/21, 1/6/22, 1/20/22, and 1/28/22. During the 12/7/21 and 12/20/21 visits, ACS informed the family about safe sleeping positions for infants. The 1/28/22 home visit was the last visit prior to the incident and the SC was observed in the kitchen. During each of the visits, the SC, MGGM, and MC were seen and safe sleep was discussed.

Foster Care Placement History

During the 10/16/21 investigation, ACS opened a service case on 10/20/21 as there was a need for services. The initial FASP reflected the SC was brought to the hospital with multiple fractures in six ribs. The SC also had a fractured right humerus. The family's service plan included parent training for the BM and BF, and case management services for the SC. The family was willing to engage in preventive services. The FSPN reflected the family was approved for resource supervised visits. The PGGM and PA were the approved resources for the visits. Resource supervised visits occurred regularly. The documentation reflected there were no concerns. The FSPN also reflected that Family Court approved the SC's discharge from foster care during a hearing that occurred on 12/1/21.

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:**

10/21/2021	There was not a fact finding	There was not a disposition
Respondent:	060801 Mother Female 23 Year(s)	
Comments:	On 10/21/21, an Article Ten Abuse petition was filed in Family Court naming the mother and father of the SC as respondents. According to ACS, the abuse petition was withdrawn and dismissed on 2/3/22 due to the SC's death.	

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