Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-21-053

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

Issue Date: May 20, 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: 4 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 12/16/2021
Initial Date OCFS Notified: 12/16/2021

Presenting Information

An SCR report alleged that on 12/7/21, the maternal grandfather fell asleep on the couch with the 4-month-old infant for approximately 30 minutes. The mother and grandmother arrived home and noticed that the infant was laying on his stomach and his head was hanging off of the side of the couch. The infant was unresponsive. Emergency medical services were contacted and the infant was transferred to the hospital at 5:00 PM. The infant remained in a coma and on a ventilator after the incident. On 12/16/21, the ventilator was removed and the infant was pronounced deceased due to cardiac arrest from unsafe sleeping.

Executive Summary

On 12/16/21, the Suffolk County Department of Social Services (SCDSS) received an SCR report regarding the death of the 4-month-old male infant that occurred on that date. At the time of the infant's death, SCDSS had an open CPS investigation, which was received on 12/7/21, after the infant was found unresponsive while in the care of the maternal grandfather on that date. At the time of the fatal incident, the infant resided with his mother and maternal grandparents. The father had been incarcerated on unrelated charges since the infant's birth.

SCDSS and law enforcement conducted a joint investigation into the infant's death. It was learned that the infant was left in the care of the grandfather on 12/7/21. The maternal aunt and grandmother arrived at the home around 4:30 PM, and they discovered the grandfather had fallen asleep on the reclining couch with the infant. The infant had fallen from the grandfather's chest and he was face down on the footrest. The infant's head was hanging off the footrest and he was unresponsive. The grandmother called 911 while the aunt and grandfather performed CPR. EMS arrived and took over CPR and transported the infant to the hospital via ambulance. The infant regained a pulse and he was placed on life support. The infant remained in a coma and on life support until his death on 12/16/21 at 11:41 AM.

The investigation revealed that the grandfather had a history of opiate use, and he took a prescribed opioid maintenance drug daily. Following the incident, law enforcement conducted a blood test and the grandfather was found to have just his prescribed opioid maintenance drug in his system. The grandfather denied being under the influence of any drugs or alcohol during the incident.

An autopsy was performed, and the results were pending at the time this report was written. Law enforcement reported no criminality regarding the infant's death, and their case remained open pending the final autopsy results.

SCDSS substantiated the allegations of DOA/Fatality, Lack of Supervision, and Inadequate Guardianship against the grandfather. SCDSS' investigation found credible evidence that the grandfather failed to exercise a minimum degree of care by not adhering to safe sleep practices. His actions/inactions in not providing proper supervision of the infant ultimately led to his death. SCDSS referred the family for mental health and bereavement services and they closed the case as there were no surviving children.

PIP Requirement

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The case was appropriately indicated and closed.

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 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: 12/16/2021 **Time of Death:** 11:41 AM

Date of fatal incident, if different than date of death: 12/07/2021
Time of fatal incident, if different than time of death: 04:30 PM

County where fatality incident occurred: Suffolk
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

How long before incident was the child last seen by caretaker? 30 Minutes

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	Male	4 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	56 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	60 Year(s)
Deceased Child's Household	Mother	No Role	Female	25 Year(s)
Other Household 1	Father	No Role	Male	29 Year(s)

LDSS Response

SCDSS investigated the infant's death by reviewing the parents' and grandparents' SCR history and records from the hospital, pediatrician, law enforcement, and fire department. They conducted a home visit on 1/22/22, and the infant's sleeping arrangements were not assessed since the family had removed all infant supplies from the home. SCDSS interviewed the mother, grandparents, aunt, and father. They notified the District Attorney's Office of the death, spoke to the source of the report, and spoke with law enforcement. Attempts to speak to the medical examiner were unsuccessful.

The grandmother reported that the aunt picked her up at work at 4:00 PM, and she checked in with the grandfather. He reported that the infant was fussy, so he was giving him tummy time. She and the aunt arrived at the home at 4:30 PM, and she immediately discovered the infant was face down, with his head hanging over the footrest. She began yelling for the grandfather to wake up and the aunt picked up the infant and began CPR while the grandmother called 911. She denied that the grandfather appeared to be under the influence of any drugs or alcohol and she said she had no knowledge of him using drugs or misusing his prescribed medication. She had no concerns for the grandfather's ability to care for the infant.

The aunt's account of the incident was consistent with the grandmother's account. She said she immediately performed CPR, then the grandfather took over CPR so she could call the mother. She had no concerns for the grandfather's ability to care for the infant. She said he had been sober for 15 years and she denied that he appeared to be under the influence of any drugs or alcohol when they arrived at the home.

The mother said she was at work when she received a call from the aunt informing her of the incident and she immediately went to the hospital. She expressed no concerns for the grandfather caring for the infant. She denied that she had seen the grandfather under the influence of drugs or alcohol at any time prior to the incident.

The grandfather stated that he was sitting in the reclining sofa and the infant was fussy. He decided to give the infant some tummy time, so he laid the infant on his chest. He fell asleep and the next thing he remembered was the grandmother yelling at him. He performed CPR until EMS arrived and took over. He said he took a prescribed opioid maintenance medication daily and he had taken his prescribed dose on the day of the incident. He denied that he had taken any non-prescribed substance or that he was impaired. He said he fell sleep on the couch while EMS rendered emergency aid to the infant, and he had no explanation as to why he was sleeping during the commotion. The grandfather refused to sign releases for his medical providers and he would not answer any additional questions about the incident.

The pediatrician's records showed the infant was last seen on 10/15/21 for a well visit and no concerns were noted. Law enforcement reported the grandfather was “nodding off” and he fell asleep on the couch after first responders arrived at the home and while life-saving measures were being performed. Hospital staff reported that the infant was in cardiac arrest when first responders arrived, and EMS resuscitated him. Hospital records showed the infant never regained consciousness. He remained on life support until it was determined he had no brain activity and it was withdrawn on 12/16/21.

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: Suffolk County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060341 - Deceased Child, Male, 4 Mons	060344 - Grandparent, Male, 56 Year(s)	DOA / Fatality	Substantiated
060341 - Deceased Child, Male, 4 Mons	060344 - Grandparent, Male, 56 Year(s)	Inadequate Guardianship	Substantiated
060341 - Deceased Child, Male, 4 Mons	060344 - Grandparent, Male, 56 Year(s)	Lack of Supervision	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐

When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was referred for mental health and bereavement services.

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)
12/07/2021	Deceased Child, Male, 4 Months	Grandparent, Male, 56 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 4 Months	Grandparent, Male, 56 Years	Lack of Supervision	Substantiated	

Report Summary:
Two SCR reports were received that alleged on 12/7/21, the infant was left in the care of the maternal grandfather at 4:00 PM. The grandfather placed the infant on his stomach on the couch for tummy time. The grandfather fell asleep on the couch next to the infant. When family members returned home at 4:30 PM, the infant was observed face down on the couch and he was unresponsive. Emergency services were contacted, and CPR was performed. EMTs arrived and transported the infant to the hospital. The infant arrived at 5:00 PM, in respiratory failure and cardiac arrest. CPR continued and the infant was intubated. A pulse was detected, and the infant was in critical condition.

Report Determination: Indicated | **Date of Determination:** 02/05/2022

Basis for Determination:
There was credible evidence that the grandfather failed to exercise a minimum degree of care when he failed to properly supervise the infant. The grandfather fell asleep while the infant was sleeping on his chest on a reclined sofa. The infant subsequently fell from his grandfather's chest to the foot rest, which caused him to become unresponsive and pass away.

OCFS Review Results:
SCDSS conducted home visits and they interviewed the mother, grandparents, father, and maternal aunt. Collateral contacts were made with law enforcement, hospital staff and the pediatrician's office. Casework activities were completed timely and the case was appropriately indicated.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/06/2021	Deceased Child, Male, 1 Days	Mother, Female, 25 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 1 Days	Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
An SCR report alleged the mother gave birth to the infant on 8/5/21. The mother and infant tested positive for methadone at delivery.

Report Determination: Indicated | **Date of Determination:** 09/15/2021

Basis for Determination:
The mother had a history of opiate use and she admitted to relapsing during her pregnancy and then using non-prescribed methadone to avoid withdrawal symptoms. The infant tested positive for methadone at birth and he experienced withdrawal symptoms. He remained in the Neonatal Intensive Care Unit until 8/21/21. The mother tested positive for methadone and fentanyl on 8/10/21 and fentanyl on 8/19/21. SCDSS filed a Neglect Petition in Family Court on 8/30/21. The infant was placed in the custody of the grandmother under Article 1017 and an order of protection was issued barring the mother from unsupervised contact with the infant.

OCFS Review Results:
SCDSS conducted home visits and they interviewed the mother, maternal grandmother and maternal aunt. The father was interviewed at jail. A plan of safe care was completed, safe sleep was discussed with the family, and a safe sleep environment was observed. Safety Assessments and the RAP were completed timely and accurately. Relevant collateral

contacts were made and the mother was referred to the appropriate services. A Neglect Petition was appropriately filed to obtain court ordered services and the case was opened for ongoing CPS services.
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

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

An SCR report dated 10/26/10 was substantiated against the grandparents for the allegation of Educational Neglect.

SCR reports dated 11/3/14 and 5/20/15 were unsubstantiated against the grandparents for allegations of Inadequate Guardianship and Sexual Abuse.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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: 09/01/2021

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: 09/01/2021

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?	☒	☐	☐	☐
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: SCDSS provided ongoing CPS Services to the family.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Adequacy of Child Protective Services casework contacts (open services)
Summary:	Face-to-face casework contacts and home visits were not conducted during the five months the ongoing CPS Services Case was opened.
Legal Reference:	18 NYCRR 432.2(b)(4)(vi)
Action:	In cases where the child protective service is the primary service provider to children named in indicated child protective services cases and their families, SCDSS must make at least two separate face-to-face contacts per month with the subject(s) and other persons named in the report, one of which must take place in the subject's home.

Preventive Services History

An ongoing CPS Services Case was opened on 9/1/21, due to the mother having a history of drug use and the mother and infant testing positive for methadone at the time of the infant's birth. A Neglect Petition was filed and the infant was placed in the grandmother's custody under Article 1017. The mother lived with the grandparents; however, an order of protection was issued barring the mother from unsupervised contact. The grandmother and aunt were approved supervisors. The mother engaged in outpatient substance abuse treatment, mental health counseling, and she enrolled in a parenting skills class. SCDSS contacted the mother's service providers to monitor her participation in services. The case closed on 2/1/22 as there were no surviving children.

The grandparents' home was not assessed during the Services Case and there was only one attempted home visit documented on 9/25/21. Although the grandfather also resided in the home he was not considered a caretaker for infant and there is no mention of him. There were no face-to-face contacts with the adults or the infant. The mother and grandmother were spoken to on the phone but there were no documented attempts to speak to the grandfather or aunt. The infant was briefly observed during a video call while he was with a babysitter on 10/25/21, and it was noted that he appeared to be free from visible marks and bruises.

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:**
09/02/2021	There was not a fact finding	There was not a disposition
Respondent:	060342 Mother Female 25 Year(s)	
Comments:	On 8/30/21, the infant was removed from the mother and placed with the maternal grandmother under Article 1017. A Neglect Petition was subsequently filed against the mother on 9/2/21. As a result of the infant's death, SCDSS withdrew the petition and the preliminary orders were vacated on 12/22/21.	

Have any Orders of Protection been issued? Yes	
From: 08/30/2021	**To:** 08/30/2022
Explain: On 8/30/21, an order of protection was issued barring the mother from consuming illegal or non-prescribed substances and from any unsupervised contact with the infant.	

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