Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-21-023

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

Issue Date: Dec 02, 2021

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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 06/13/2021
Initial Date OCFS Notified: 06/13/2021

Presenting Information

An SCR report was received with concerns that on 6/13/21, the father was the sole caretaker of the three-month-old subject child when the child died due to cardiac arrest. The father was in the back seat of a vehicle for several hours sleeping with the child on his chest. The father awoke and found the child unresponsive. The father attempted CPR but was unsuccessful. For approximately three hours, the father and the mother failed to seek medical treatment for the child. The parents drove around with the child in his car seat, unresponsive. The mother and father did not have a reasonable explanation for the child's death.

Executive Summary

This fatality report concerns the death of a three-month-old male subject child that occurred on 6/13/21. On that same date, Suffolk County Department of Social Services (SCDSS) received the fatality report and investigated the child's death. An autopsy was completed; however, the final report had not yet been issued at the time of this writing, and the cause and manner of death remained pending.

At the time of the child's death, he resided with his mother at a family shelter. The child's father was homeless. There was an active stay away order of protection in place against the father regarding the subject child due to the father's history of substance abuse and physical assaults against the mother. The father had two other children, ages 13 and 16 years old, with whom he had no recent contact. The mother had one other child, 17 years old, who was in the care and custody of her biological father. The investigation revealed that on 6/12/21, the mother, father and child were together in a vehicle, with the father as the driver. The car was pulled over by police and the mother was arrested for outstanding warrants. The record did not provide any further detail about the warrants. The father was permitted to leave the scene with the child. It was unknown if the arresting officers were aware of the active order of protection regarding the child at the time of this incident. Due to the father's homelessness, he and the child spent the night in the car, in the parking lot of a fast-food restaurant. The father and child slept in the back seat, with the child lying face down on the father's chest. On 6/13/21, the father awoke and found he was still chest-to-chest with the child; however, the child was unresponsive. The record did not reflect what time this occurred, or how long it had been since the father last saw the child alive. The father did not contact emergency services or seek any medical attention for the child. The father instead drove the child to the hospital and parked in the parking lot. Hospital security surveillance cameras were reviewed by law enforcement and it was found the father remained in the vehicle with the child for 90 minutes, until the mother arrived and brought the child into the emergency room. Hospital staff attempted life saving measures, but they were unsuccessful. The child was pronounced deceased at 4:25PM on 6/13/21.

SCDSS spoke with family members and collateral sources, which included law enforcement, medical staff, and the medical examiner. Due to the parents' noncompliance with the order of protection, both were substantiated for Inadequate Guardianship. Further, the father was substantiated for Lack of Medical Care after failing to seek emergency treatment for the subject child. A medical causal link between the father's actions and the child's death was not discovered, and therefore the allegation of DOA/Fatality was unsubstantiated. Neither parent was charged criminally for the death of the child, and SCDSS indicated and closed the investigation.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
SCDSS gathered information to determine the allegations. There were no other children in the parents care, and safety assessments were not required. The parents had additional children of whom they did not have custody, and SCDSS assessed their safety 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:
The case record reflected supervisory consultations throughout the investigation. The level of 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: 06/13/2021 **Time of Death:** 04:25 PM

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

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
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	Male	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	38 Year(s)

LDSS Response

On 6/13/21, SCDSS received the subsequent SCR fatality report regarding SC. SCDSS had been involved with the family since 4/13/21, after an initial CPS investigation was opened due to concerns surrounding domestic violence in the home and SF's ongoing drug abuse. A Neglect Petition was filed against SF on 5/20/21, and the family began receiving court ordered services thereafter. Upon receipt of the fatality report, SCDSS initiated their investigation within 24 hours and coordinated their efforts with their MDT. The safety of the surviving half-siblings was assessed, and it was determined none of them had any regular contact with SM or SF.

On 6/13/21, LE advised SCDSS of their interviews with the parents: LE reported that on 6/12/21, SM was pulled over in a car with SF and SC and arrested for outstanding warrants. LE stated SM was brought to the precinct and SF left with SC; it was unknown if the arresting officer was aware of the OP between SF and SC. LE reported a family member wired SF money for a motel room, but SF decided to buy formula and fast food. SF and SC stayed the night in the car in a fast-food parking lot, where SF fell asleep in the back seat with SC on his chest. LE reported SF last fed SC around 7:00AM on 6/13/21 and put the car air conditioner on low. LE stated SF fell back to sleep chest-to-chest with SC. LE explained according to SF, when he awoke, SC was unresponsive and felt hot, so he opened a car window and splashed water on SC. LE explained SF then drove to a nearby hospital where he could be seen on video surveillance sitting in the car with SC for 90 minutes until SM arrived; SF never called 911 or brought SC into the hospital during that time. LE said neither parent appeared under the influence, and SF was arrested at the hospital for violating the OP. LE reported the ME's

preliminary findings noted no signs of abuse, and it appeared SC had been dead for several hours.

On 6/15/21, SCDSS interviewed SM. SM explained SF was leaving for inpatient drug treatment on 6/15/21, so they spent the weekend together. SM reported she and SC were residing at a homeless shelter at that time, and SF was not allowed to stay overnight there, so they spent 2 nights at a motel. SM stated on 6/12/21, she, SF and SC were in their car and were pulled over by LE; SM was arrested and LE let SF go with SC. SM stated she was released the next day and got in touch with SF via phone. SM said SF told her SC was not okay and they were in the car in the hospital parking lot. SM said MGM drove her to the location and she found SC to be "solid white." SM said she felt he had been dead for a while. SM said she ran inside the hospital with SC. SM denied she or SF had been using drugs, and they were taking their controlled substances as prescribed. SM stated she was aware she was violating the OP by allowing contact with SF. She stated SF may have waited to get medical assistance for SC because she believed he had a cognitive limitation due to brain damage. SM denied SF would have intentionally harmed SC.

On 6/17/21, SCDSS interviewed SF at prison. SF's recollection of events corroborated those provided to SCDSS by LE. SF stated he was aware of the OP but did not feel it was needed. SF denied any recent drug use. He said when he found SC unresponsive, he panicked, and that is why he waited so long before going into the hospital.

By the close of the fatality investigation, SCDSS made attempts to follow up with the parents, but they did not respond. SCDSS found evidence to substantiate the allegations of IG and LMC against the parents; however, there was no causal link found between the SF's actions and SC's death. Therefore, the allegation of DOA/Fatality was unsubstantiated. SCDSS amended the petition against SF to include the death of SC, and a neglect petition was filed against SM; however, both petitions were withdrawn without prejudice on 9/29/2021, and the services case was closed.

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
Comments: This fatality investigation was conducted by the Suffolk County MDT.

Was the fatality reviewed by 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
058941 - Deceased Child, Male, 3 Mons	058943 - Father, Male, 38 Year(s)	DOA / Fatality	Unsubstantiated
058941 - Deceased Child, Male, 3 Mons	058943 - Father, Male, 38 Year(s)	Inadequate Guardianship	Substantiated
058941 - Deceased Child, Male, 3 Mons	058943 - Father, Male, 38 Year(s)	Lack of Medical Care	Substantiated
058941 - Deceased Child, Male, 3 Mons	058942 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated

058941 - Deceased Child, Male, 3 Mons	058942 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Substantiated
058941 - Deceased Child, Male, 3 Mons	058942 - Mother, Female, 40 Year(s)	Lack of Medical Care	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

SCDSS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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:
The subject child was the only child that resided in the household, but the mother and father had additional children with whom they did not have custody or any recent contact. Those children were deemed safe with their caregivers. A RAP was not required for those children. A neglect petition was filed against the mother and the pending petition against the father was amended to include the fatality; however, both petitions were withdrawn on 9/29/21.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
The surviving half-siblings were assessed as safe and did not need to be removed as a result of this fatality report.

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:**
07/16/2021	There was not a fact finding	There was not a disposition

Respondent:	058942 Mother Female 40 Year(s)
Comments:	A neglect petition was filed against the mother and amended against the father after the death of the subject child. Neither parent had any other children in their care. The petitions were withdrawn without prejudice on 9/29/21.

Criminal Charge: Other - Criminal Contempt **Degree:** NA

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Pending	SF	Unknown	Unknown
Comments:	The father was charged and arrested for criminal contempt after not complying with the order of protection issued regarding the subject child.		

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:
Grief and bereavement services were offered to the parents following the fatality. The open services case continued; however, the parents did not continue to engage. SCDSS assisted the parents with securing needed housing, but they left the shelter on their own accord prior to case closure.

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 other children in the household. The surviving half-siblings had no recent contact with their parents and had never met the subject child.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Service referrals were provided to the parents following the death of the child.

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? No
Were there any siblings ever placed outside of the home prior to this child's death? Yes
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:
- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ 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)
04/13/2021	Deceased Child, Male, 1 Months	Mother, Female, 40 Years	Inadequate Guardianship	Substantiated	No

Deceased Child, Male, 1 Months	Father, Male, 38 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 1 Months	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Substantiated

Report Summary:
This SCR report was received with concerns that on 4/11/21, SF pinned SM against a wall by holding her hair while SC was present. There were further concerns that on 4/12/21, SF was high on drugs and forced his way into SM and SC's unit at the family shelter where they resided. It was unknown if he became violent with SM. On 4/13/21, at 1:00AM, SM and SC left the shelter with SF, and SM also had a history of substance abuse.

Report Determination: Indicated | **Date of Determination:** 06/24/2021

Basis for Determination:
SCDSS interviewed family and collaterals. SM reported SF pinned her by her hair against a wall while SC was present, but SC was not harmed. SM and SF denied any other incidents. SM stated she was 6 years sober. SF admitted to relapsing during this investigation, but denied using while caring for SC. On 5/20/21, a neglect petition was filed against SF, and a stay away OP was issued against SF with SC as the protected party. SM tested negative for drugs. SF tested positive for drugs. SF overdosed during the case and as a result suffered seizures, possible brain damage, and briefly stayed in the hospital ICU. The investigation was indicated, and a mandated services case was initiated on 6/11/21.

OCFS Review Results:
This investigation met all statutory requirements.

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

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

From 2005 to 2012, the father was named as a subject in four indicated CPS investigations with common allegations of IG and PD/AM. From 1997 to 2008, the mother was named as a subject in two indicated CPS investigations with common allegations of IG, LS, PD/AM and OTH/COI.

Known CPS History Outside of NYS

There was no know 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: 06/11/2021

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: 06/11/2021

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:
Court ordered services were opened in response to a neglect petition filed against the father.

Preventive Services History

On 6/11/21, an FSI stage was opened after a neglect petition was filed against the father due to concerns of domestic violence and drug abuse. The stage was not progressed until 6/14/21. An OP was issued protecting the subject child, and DSS supervised visitation was ordered. Two days after the case initiation, the subject child died. Although SCDSS amended the petition against the father to include the death of the child, and filed an additional petition against the mother, both petitions were ultimately dismissed without prejudice. The record did not reflect the reasoning for the dismissal. There were no other children in the parents' custody, and the services case was closed on 9/29/21.

In February 2009, the father was involved in an open services case regarding his two other children after concerns regarding domestic violence and drug abuse were discovered. The case was closed in December 2010 after the children's biological mother obtained custody and the father agreed to drug treatment. The children were deemed safe with their 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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
05/28/2021	There was not a fact finding	Order of Supervision
Respondent:	058943 Father Male 38 Year(s)	
Comments:	A neglect petition was filed against against the father after concerns arose surrounding drug use and domestic violence. The father was ordered to DSS supervised visitation only, and a full stay away order of protection was issued with the child as the protected party. This petition was eventually amended to include the death of the child, and then withdrawn without prejudice on 9/29/21.	

Have any Orders of Protection been issued? Yes	
From: 05/20/2021	**To:** 05/20/2022
Explain: A full stay away order of protection was issued against the father with the subject child as the protected party after concerns surrounding domestic violence and drug abuse arose.	

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