Child Fatality Report

Report Identification Number: SV-17-006

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

Issue Date: Jul 20, 2017

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		
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
CPR-Cardiopulmonary Resuscitation		
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	

Case Information

Report Type: Child Deceased
Age: 5 month(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 03/06/2017
Initial Date OCFS Notified: 03/07/2017

Presenting Information

The SCR report alleged on 3/6/17, while in the care of the MGM, the 5-month-old SC was put in a "bumpy seat" by MGM and placed on top of a counter. The MGM turned around and SC fell off the counter 3-4 feet onto the floor. The SC hit her head on the floor and sustained a subdural hematoma (bleeding from the brain). The SC also sustained a bump on her head. The SC had surgery and was taken into the pediatric intensive care unit where she was pronounced dead at 9:47pm on 3/6/17. The SC's parents and siblings had unknown roles. The MGM was a person legally responsible, given she had been regularly caring for the SC for the past several months.

Executive Summary

On 3/6/17, the SCR received a report regarding life-threatening injuries sustained by the 5-month-old female SC while in the care of her MGM. Another report was made on 3/7/17 alleging SC died due to her injuries.

Suffolk County Department of Social Services (SCDSS) investigated the reports, as it was alleged the MGM buckled SC in a “bouncy seat,” placed her on top of a counter, and turned away for a moment. LE reported the seat was known as a “Bumbo Seat,” described as a plastic seat where a baby sits up and whose legs stick out of the seat. The seat also had a buckled strap to secure a child. SC was described by the family as an active baby who commonly reached for items and kicked her legs as was appropriate to her age/level of development. During the brief time MGM was distracted, SC reached the counter top with her feet and pushed herself off the counter, which was about 3-4 feet off the ground. The SC landed face-down, hitting her head on the ground. Shortly after impact, SC became limp and unresponsive. 911 was called and SC was taken to the hospital. The SC had surgery, though she did not fully recover and was pronounced deceased later that night. In observations of the scene where the incident occurred, LE described that given SC’s ability to reach the counter top and push off, her activity level, and the smoothness of the granite counter top, the seat would have moved, “like it was on ice.”

SCDSS assessed safety of the SS, ages 2, 6, and 17, within 24 hours of both reports. SCDSS found the SS were not in immediate or impending danger of serious harm, given there were no concerns for the children’s parents. Through familial and collateral contacts with medical professionals, SCDSS concluded the incident was unintentional. SCDSS described MGM was “culpable careless” for the following reasons: MGM placed SC in the seat on an elevated surface, despite the warning label advising against it; MGM was distracted while SC was in this unsafe environment, tending to other tasks; and, MGM failed to notice SC moving the seat with her feet, nearing the edge of the counter. These factors resulted in the MGM failing to protect SC from impending danger, resulting in SC sustaining a life-threatening brain bleed and subsequently dying.

SCDSS gathered collateral information, including but not limited to conversations with first responders, correspondence with the ME, and evidence of the scene. Although the autopsy report was not complete at the time the case was closed, conversations with the ME clarified that the injuries were likely to have been sustained in the manner described and incident was believed to be unintentional. SCDSS concluded there was credible evidence that MGM’s failure to provide SC with a minimal degree of care had a direct connection to her death. For these reasons, SCDSS IND the report against MGM for allegations of IG, II, LS, and DOA/Fatality regarding SC. The allegation of S/D/S was Unsub as medical documentation did not provide evidence that SC had swelling, dislocations or sprains.

The MGM resided out of state, except for the recent months she came to help care for SC, and had no Child Protective Services (CPS) history New York; however, there was no record that a CPS history check was done in her primary state of residence. SCDSS completed timely and accurate assessments, and offered and encouraged services

specific to the family's loss. The family chose to use their own resources.

SCDSS was cited for failing to request out-of-state CPS records in both the fatality and open CPS investigations. Only one action is required to address this issue. In response, SCDSS will submit a Program Improvement Plan (PIP) to the Regional Office (RO) which will identify what action SCDSS has taken, or will take, to address this. If a PIP is currently in place, the plan will be reviewed and revised as needed. Nassau County DSS was also cited in a historical case, and will respond to the RO in the same manner.

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:
Sufficient information was gathered to determine all allegations, and the decisions made regarding those allegations were appropriate. Sufficient information was gathered and appropriately recorded on the Investigation Determination safety assessment. All casework activities were completed, commensurate with case circumstances.

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 determination of allegations was appropriate, as was the decision to close the case. The case record had documentation of detailed conversations with supervisors and administrators.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source

Child Fatality Report

Summary:	There was no CPS history check done for MGM in her primary state of residence (where she resided prior to the recent months she had been caring for the SC). This was an important inquiry for this case, given the circumstances.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	A full child protective investigation must include the activity of obtaining information from persons and/or agencies who may have information relevant to the allegations in the report and to the safety of the children. Federal legislation allows for interstate sharing of information at times when necessary in order to conduct a child abuse investigation of the subject of the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/06/2017 **Time of Death:** 09:47 PM

Time of fatal incident, if different than time of death: 08:50 AM

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: 09:00 AM
Did EMS to respond to the scene? Yes
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: Sitting

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? No
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☒ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☐ Asleep
- ☐ Impaired by illness
- ☐ 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	Father	No Role	Male	36 Year(s)

Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	50 Year(s)
Deceased Child's Household	Mother -	No Role	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

SCDSS assessed and documented safety of the 3 SS within 24 hours of both reports. SCDSS recorded several case consultations with supervisors and administrators from the time the case initiated through the case conclusion. SCDSS confirmed the MGM was a person legally responsible for the SC, given she provided regular care to the infant multiple times a week while the parents either worked or slept (given their differences in shift hours).

SCDSS found the 3 SS, ages 2, 6, and 17, were not in immediate or impending danger of serious harm at any point throughout the investigation. Prior to the incident that lead to the SC's death that occurred at approximately 8:50am, all 3 SS were home with the MGM. The BM had left for work at 6:30am, and the BF had not yet returned home from his job working the night shift. Just prior to the incident, the 17-year-old SS walked the 6-year-old SS to the bus stop and noticed the SC in the chair on the counter with MGM tending to her. The SC was in the same position with MGM close by when he returned home. Shortly after, from a nearby room, he heard a "thump" and went in the kitchen, observing the SC face down on the floor in her seat, crying. MGM assessed the child and noticed shortly after picking her up, the SC stopped crying and went limp. MGM called the SC's parents and made the decision to call 911.

There was no evidence to suggest the SC had any preexisting medical conditions or was taking any medications or remedies. There was also no evidence that the MGM was impaired at the time of the incident or had a history of any substance abuse, though there was no record that this was inquired of MGM. The 17-year-old SS was asked about any drug or alcohol use by anyone in the home, which he denied. The SC's parents were appropriately upset over what occurred, and the BF in particular was angry at the MGM for what occurred under her supervision. The case record reflects that the MGM did not resume any caregiving responsibilities for the SS following the fatality, as she went to stay with the MGGM before she returned to her home state. SCDSS was diligent in offering services for different types of grief-related counseling on more than one occasion. The record revealed no other safety concerns or service needs for the family, and the case was closed.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: The investigation was conducted jointly between SCDSS, LE, medical professionals, and other members of the MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in Suffolk County.

Child Fatality Report

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
038761 - Deceased Child, Female, 5 Month(s)	036644 - Grandparent, Female, 50 Year(s)	Lack of Supervision	Substantiated
038761 - Deceased Child, Female, 5 Month(s)	036644 - Grandparent, Female, 50 Year(s)	DOA / Fatality	Substantiated
038761 - Deceased Child, Female, 5 Month(s)	036644 - Grandparent, Female, 50 Year(s)	Inadequate Guardianship	Substantiated
038761 - Deceased Child, Female, 5 Month(s)	036644 - Grandparent, Female, 50 Year(s)	Internal Injuries	Substantiated
038761 - Deceased Child, Female, 5 Month(s)	036644 - Grandparent, Female, 50 Year(s)	Swelling / Dislocations / Sprains	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 requested and received pertinent information from necessary collateral contacts. SCDSS spoke with all family members on the case and interviewed all children except the 2-year-old SS, who was not developmentally able to be interviewed.

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 safety 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	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: There was no removal necessary at any point during the investigation.				

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	Offered, but	Offered, Unknown	Needed but not	Needed but	N/A	CDR Lead to

	Death	Refused	if Used	Offered	Unavaliable		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:
Funeral assistance was offered but parents stated they were able to pay themselves. Parents were provided bereavement package for the family and were urged to seek help, but they identified using their own resources. No other service needs were identified.

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? No
Explain:
Grief-related services were offered and encouraged to the parents, and directly to the 17-year-old child given his age/level of development, though the record reflects that services were not provided directly while the case was open.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Grief-related services were offered and encouraged to the parents, on more than one occasion and through more than one provider. Similar services were offered to the MGM after SCDSS found information for those available in her area. The record reflects that services were not provided directly while the case was open.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	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?	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
- ☒ 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)	Status/Outcome	Compliance Issue(s)
03/06/2017	Deceased Child, Female, 5 Months	Grandparent, Female, 50 Years	Lack of Supervision	Indicated	Yes
	Deceased Child, Female, 5 Months	Grandparent, Female, 50 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Female, 5 Months	Grandparent, Female, 50 Years	Internal Injuries	Indicated	

Report Summary:
SCR report alleged on 3/6/17, the MGM was caring for the SC and not adequately supervising her. The SC was in a "bumpy" seat up on a counter top when MGM was preparing a bottle for her. SC fell off the counter and hit her head on the hard floor. SC sustained a brain bleed as a result and was in surgery at the time of the report. SC's parents and other children (ages 2, 6, and 17) had unknown roles.

Determination: Indicated | **Date of Determination:** 05/01/2017

Basis for Determination:
SCDSS confirmed the narrative to be accurate with what occurred on the date of the incident. Family confirmed SC was very active, often reaching for objects in her seat, and could also reach the counter top with her feet from the seat, making it easy for her to move about in it. MGM was indicated for failing to properly supervise the child while she was in this unsafe environment. SC hit her head on the floor when she fell off the counter. SC sustained a life threatening brain bleed and died as a result of the injury.

OCFS Review Results:
SCDSS assessed safety of the SS within 24 hours and found there to be no immediate safety concerns for them. SCDSS fully completed all casework activity in a timely fashion, commensurate with case circumstances. SCDSS appropriately determined the allegations given the information obtained during the investigation. There was no CPS history check for the MGM in her primary state of residence. MGM was the only alleged subject on the report, who primarily resided out of state (with the exception of the recent months she had been caring for the SC).

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
Despite the fact that MGM was a subject regarding a child fatality and serious abuse allegations, there was no CPS history check for the MGM in her primary state of residence. MGM was the only alleged subject on the report, who primarily resided out of state (with the exception of the recent months she had been caring for the SC).

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
A full child protective investigation must include the activity of obtaining information from persons and/or agencies who may have information relevant to the allegations in the report and to the safety of the children. Federal legislation allows for interstate sharing of information at times when necessary in order to conduct a child abuse investigation of the subject of the report.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/23/2016	Sibling, Male, 17 Years	Other Adult - SS's BM, Female, 34 Years	Other	Unfounded	Yes
	Sibling, Male, 17 Years	Father, Male, 36 Years	Other	Unfounded	

Report Summary:
Nassau County Family Court requested that a court-ordered investigation be conducted by Nassau County Department of Social Services (NCDSS), with a return court date of 1/7/2017. The concern was that the SS had excessive absences and was failing school as a result; however, the report noted the SS was 17 years old and was not legally mandated to attend.

Determination: Unfounded **Date of Determination:** 01/11/2017

Basis for Determination:
The parents identified having made numerous efforts to address the absenteeism issue; furthermore, the child identified knowing his parents had made this effort as well. NCDSS found no other safety concerns for the child, and due to the parents' continued commitment to address the issue, the report was unfounded.

OCFS Review Results:
NCDSS adequately assessed safety of the SS at the required points in the investigation. NCDSS found there to be no safety concerns for any child in either household. NCDSS reviewed safe sleep practice with the BF whose child was under the age of 1 and verified a safe sleep environment. Accurate assessments of safety and risk were completed on time. Though they were identified and collateral information was gathered for them, NCDSS did not add additional household members to the case, interview them, or notify the other adults in writing; this included children.

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

Issue:

Face-to-Face Interview (Subject/Family)

Summary:

Additional relatives were identified as residing in both households, but those children and adults were never added to the case. Only one of the adults identified as living with the BF was spoken with, and none of the additional children in either household were interviewed (those that were of age/developmental level to participate in an interview).

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(a)

Action:

A full Child Protective investigation shall include face-to-face interviews with subjects of the report and family members of such subjects. Such interviews or reasons why an interview was not possible should be documented in progress notes.

Issue:

Failure to provide notice of report

Summary:

The record does not reflect that the subjects or other adults in the household were provided written notification of the report.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

Nassau County Department of Social Services will mail or deliver notification letters to subject(s) and parent(s) within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

[redacted]

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

There is no CPS history more than three years prior to the fatality; however, it is unknown if there is any CPS history for the MGM in her state of residence, as there is no documentation that a check was completed for MGM in that state.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State; however, it is unknown if there is any CPS history for the MGM in her state of residence. MGM primarily resided out of state (with the exception of the 3 months she had recently been caring for the SC) though there was no documentation that a check was completed for MGM in that state.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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

Additional Local District Comments

The language of the 18 NYCRR 432.2 (b)(3)(ii) is sufficiently vague as to provide flexibility in case by case application:

"(ii) The full child protective investigation must include the following activities: ...Obtaining information from the reporting sources and other collateral contacts, which MAY include but are not limited to, hospitals, family medical providers, police, social service agencies and other agencies providing services to the family, relatives, extended family members, neighbors, and other persons who may have relevant information in the report and to the safety of the children..."

In the instant case, the subject of the report was not a parent, guardian or custodian; she was a visiting maternal grandparent. The nature of the death was accidental. The surviving children were assessed to be safe.

In our judgment, Suffolk made sufficient appropriate collateral contacts in order to gather enough credible evidence to make a determination in this case and appropriately assess for service needs of the family. OCFS agreed with our determination.

We agree that in other circumstances, obtaining information regarding a subject's CPS history would be imperative, such as in cases in which the subject was the parent or guardian with ongoing legal responsibilities. In this case, out-of-state information concerning the subject MGM would not have been relevant to the indicated determination, our actions, or the safety of the children.

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