Child Fatality Report

Report Identification Number: SV-17-024

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

Issue Date: Dec 04, 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	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		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Nassau
Gender: Male
Date of Death: 01/26/2017
Initial Date OCFS Notified: 07/06/2017

Presenting Information

The SC and his family were involved in an open Child Protective Services (CPS) investigation at the time of the 2-year-old SC's death. The SC suffered from a severe illness, which often required hospitalization. The SC's death was not reported to the SCR as being suspicious of abuse or maltreatment. OCFS became aware of the death several months after the investigation closed, on 7/6/2017. At that time, the required 7065 Agency Reporting Form was completed. The reporting form stated the SC passed away on 1/26/2017 at home with his mother and nurse present, reportedly as a result of his illness.

Executive Summary

Nassau County Department of Social Services (NCDSS) had been involved with the family beginning on 1/10/2017, as it was alleged the BM was unable to adequately care for the SC who had extensive medical needs. NCDSS contacted the source, who noted serious concerns that BM was not aware how critical the SC's condition was. The source stated this could result in BM not providing SC with an appropriate level of care, and could also create risk in the handling of his medical equipment. It was further alleged the BM's MH issues impacted her actions and decisions regarding the SC's care. NCDSS confirmed the SC had medical issues that required in-home nursing care and frequent hospitalizations. Prior to the fatality, NCDSS spoke with a hospital social worker and doctor, who reported BM appeared to be adequately meeting the SC's level of medical needs. NCDSS further concluded no concern for MH issues.

The 2-year-old SC passed away during the open CPS investigation with NCDSS. NCDSS learned of the death on 3/10/2017, when the CW contacted the BM by telephone. The BM informed NCDSS that the SC died on 1/26/2017. NCDSS made a home visit on 3/10/2017, and the only thing that was noted about the SC was how BM discussed that SC's medical condition had worsened and his life span had not been expected to be long. The SC's medical conditions were known to NCDSS due to the open investigation and an historical case, though NCDSS did not obtain confirmation as to exactly how the SC died. Although the death had not been reported to the SCR, it was not evident that NCDSS discussed the circumstances of the death with the BM or any collateral contacts. The 5-year-old SS was seen at the home visit, and it was noted there were no safety concerns for him. NCDSS ended their involvement with the family later that day by closing the investigation, prior to speaking with the rest of the family (BF and MGM) or offering any type of services. Much remained unknown about the death as NCDSS did not document whether any efforts were made to gather information. Further, the closing of the case on the date NCDSS learned of the death showed any undocumented efforts to request information was not followed up on.

Since the investigation remained open at the time NCDSS learned of the fatality, it was relevant for NCDSS to obtain as much information as possible regarding the facts and circumstances of the death. This information-gathering was essential for the involved mandated reporters to determine whether there was reason to suspect the death was a result of abuse or maltreatment, especially given the nature of the initially reported allegations and the fact that the investigation was ongoing. Instead, the investigation was closed once NCDSS learned of the death.

NCDSS alerted the OCFS Spring Valley Regional Office of the death on 7/6/2017, past the required 24-hour timeframe, due to a reported agency oversight. The reporting form noted the SC died while at home with the BM and nursing staff present, though this was not noted in the case record. NCDSS was not able to provide OCFS with any medical documentation to confirm any fatality-related information, nor was it apparent that any information was sought during the open case.

Practice issues were noted from this review of the open investigation, as well as the historical case. These issues are identified under the CPS History section below. In response, NCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days identifying what action NCDSS has taken, or will take, to address this. If a PIP is currently in place, NCDSS will review the plan 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?** 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?** Unable to determine - insufficient documentation.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
There was initially sufficient information to determine the allegations; however, the SC died, and NCDSS did not follow up as to the existing LM allegations and whether they played a role. There was lack of information-gathering about the death upon which to document an appropriate response to verify no reasonable cause to suspect abuse or neglect related to the fatality.

Was the decision to close the case appropriate? Unknown

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The case was closed prior to the offering of services to the parents, caregivers, and SS. Insufficient information was gathered about the death, upon which to conclude there was no related suspicion of abuse or maltreatment. Other service needs were not explored or offered.

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: 01/26/2017 **Time of Death:** Unknown

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

County where fatality incident occurred: Nassau
Was 911 or local emergency number called? Unknown
Did EMS respond to the scene? Unknown
At time of incident leading to death, had child used alcohol or drugs? Unknown
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? Unable to determine

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	No Role	Male	2 Year(s)
Deceased Child's Household	Father	No Role	Male	25 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	69 Year(s)
Deceased Child's Household	Mother	No Role	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)

LDSS Response

NCDSS was involved with the SC and his family beginning on 1/10/2017 after a report was made to the SCR alleging the BM was not adequately caring for the SC's special medical needs. NCDSS determined early in the investigation the BM was in fact meeting all of SC's needs, as well as the SS. On 1/20/2017, the NCDSS supervisor noted the intention was to make follow-up visits to the family, offer services if necessary, and continue to assess for risk and safety throughout the course of involvement.

The next contact with the family was on 3/10/2017, when the NCDSS CW called the BM. At that time, the BM informed the CW that SC had passed away on 1/26/2017. She was agreeable to a home visit, and at such visit later that day, BM informed the CW that the life span for the SC's disease was not long. She indicated the SC had become worse and spent the majority of his time in the hospital. There was no documentation that the CW attempted to elicit any information surrounding the cause and circumstances of the SC's death. It was noted the CW interacted with the SS at this time, and the CW assessed there to be no safety concerns for him. The investigation was then closed on this date, completing no further investigative activities.

NCDSS unsubstantiated the initial allegations against BM, citing conversations with hospital staff prior to the fatality. These collaterals confirmed the BM had provided the SC with the level of medical care he needed. NCDSS was also aware

the SC had history of hospitalizations and medical complications due to his illness. NCDSS closed the case prior to speaking with the rest of the family or offering any fatality-related services.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: The fatality was not reviewed by the Nassau County Child Fatality Review Team, and the case record did not show if a review was planned.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
Law Enforcement	☐	☐	☐	☒
Pediatrician	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☐	☐	☒
Was a death-scene investigation performed?	☐	☐	☐	☒
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
Due to minimal information gathered about the fatality, it is unclear whether LE or a ME was involved in the fatality. No effort was documented as being made to get information about the death from the hospital.

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?	☐	☐	☒	☐
Explain: Though there was an open investigation, NCDSS did not learn of the SC's death until more than 30 days after the day he died. There was no SCR report regarding the death. Once they learned of the death, NCDSS made a home visit and observed the SS and noted there were no safety concerns for him at the time.				

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 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:
No children were removed.

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	Needed but 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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
No services were offered for the SS as a result of the fatality. His level of service need was not explored.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
No services were offered for the BM, BF, or MGM as a result of the fatality. BM's level of service need was not

explored, and she was not offered any fatality-related services. BF and MGM were not spoken with after NCDSS learned of the fatality, thus their service needs were never explored and they too were never offered services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
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?	Yes

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)
01/10/2017	Deceased Child, Male, 2 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 27 Years	Lack of Medical Care	Unfounded	

Report Summary:
The SCR report alleged BM had a history of untreated MH issues which made her unable to adequately care for the SC. The SC allegedly had medical issues that required 24-hour nursing care, as the SC needed a ventilator and feeding tube. The BM refused to allow this level of care, and tampered with the ventilator against medical advice. When the BM tampered with the ventilator, the SC had seizures as a result.

Determination: Unfounded **Date of Determination:** 03/10/2017

Basis for Determination:
The BM denied having MH issues and NCDSS did not document suspicion of MH issue. BM denied tampering with the SC's ventilator. NCDSS verified SC's diagnosis of a severe disease requiring medical equipment and care. BM did refuse 24-hour nursing care, but medical professionals confirmed 24-hour care was not required. Medical staff noted BM took excellent care of the SC. SC died during this investigation, and it was noted his medical condition was the cause. Although the death was not reported to the SCR, the official cause and manner of death was never confirmed by NCDSS. NCDSS appropriately determined the allegations after confirming the SC's medical needs were being met prior to his death.

OCFS Review Results:
NCDSS investigated the allegations, but failed to request information about the death to adequately assess whether there was suspicion the death was a result of abuse or neglect. NCDSS did not offer any services upon learning of the fatality, and failed to offer services when needs were identified. Prior to the fatality, the BF and MGM were not interviewed outside of allegation-focused questions (to further assess safety and risk). The 7-day safety assessment was late. The BF and MGM were not notified of the report in writing, and they were not spoken with after the death to assess for service needs. NCDSS failed to notify the Regional Office of the death in the amount of time required.

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

Issue:

Failure to Offer Services

Summary:

Prior to the fatality, a supervisor noted services would be offered given the circumstances of the CHN's medical conditions and other identified areas of potential need. This was never completed.

Legal Reference:

SSL 424(10); NYCRR 428.6

Action:

NCDSS will explore areas of potential service needs with all family members with whom they are involved. NCDSS will appropriately respond to changing circumstances, and if service needs are identified, NCDSS will make the appropriate referral to preventive or community-based services in an effort to determine whether there are services that can benefit the family.

Issue:

Failure to provide notice of report

Summary:

There was no documentation that the BF or MGM were provided with Notice of Existence letters.

Legal Reference:

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

Action:

NCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report 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.

Issue:

Timely/Adequate Seven Day Assessment

Summary:

The 7-day safety assessment was completed 3 days late.

Legal Reference:

SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:

NCDSS will complete all safety assessments in the amount of time required.

Issue:

Overall Completeness and Adequacy of Investigation

Summary:

Upon learning of the death, NCDSS did not obtain information as to the cause/circumstances to adequately determine whether there was reason to suspect the death was due to abuse or neglect. Interviews with adults were allegation-focused and did not elicit information about other aspects of safety and/or risk. No services were offered in identified areas of need, nor in response to the fatality.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:

NCDSS will explore elements of safety and risk with all caretakers, rather than allegations only. NCDSS will make diligent efforts to gather facts and circumstances about deaths which occur in open cases but are not initially reported to the SCR. NCDSS will offer services when necessary and appropriate.

Issue:

Adequacy of services following the fatality

Summary:

No services related to the fatality were documented as being offered to any of the family members. The BF and MGM were never contacted following the fatality, in an effort to explore potential service needs.

Legal Reference:

18 NYCRR 432.2(b)(4);428.6

Action:

NCDSS will explore areas of potential service needs with all family members with whom they are involved. NCDSS will appropriately respond to changing circumstances, and if service needs are identified, NCDSS will make the appropriate referral to preventive or community-based services in an effort to determine whether there are services that can benefit the family.

Issue:

Failure to report death of child in open CPS or Preventive/CPS services case in timely manner

Summary:

NCDSS learned of the SC's death while their investigation was open, on 3/10/2017. Though required to notify the Regional Office within 24 hours, NCDSS did not notify them until 7/6/2017.

Legal Reference:

06-OCFS-LCM-13

Action:

All authorized agencies must report to the Regional Office the death of a child involved in an open protective or preventive case within 24 hours of death or as soon thereafter as the agency becomes aware of the death.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/30/2015	Deceased Child, Male, 6 Months	Mother, Female, 25 Years	Lack of Medical Care	Unfounded	Yes
	Deceased Child, Male, 6 Months	Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	

Report Summary:

The SCR report alleged BM was cognitively delayed, and her limitations impaired her ability to care for the SC. The SC had no brain activity and relied on an apparatus for breathing, and a gastronomy feeding tube for nourishment. The BM's limitations posed a safety risk to the SC. For example, she was alleged to have tampered with the SC's tracheotomy tie causing the SC to stop breathing, did not give him oxygen, and caused him to go into arrest. This happened on more than one occasion. The BM's inability to understand the seriousness of the SC's medical condition was allegedly concerning, as she had expressed not believing the child had no brain activity.

Determination: Unfounded | **Date of Determination:** 09/25/2015

Basis for Determination:

NCDSS found BM was not cognitively delayed and she routinely met the needs of the SC, who required special medical care. NCDSS spoke with the family's nurse who was in the home 20 hours a day and confirmed the BM was not neglectful. NCDSS found the allegation that BM tampered with the SC's breathing tube on more than one occasion was false. NCDSS confirmed an incident where the tube was accidentally dislodged while BM was cleaning it, but BM responded appropriately and immediately. NCDSS found both the children's needs were met in the care of BM, and BF, who was involved but resided outside the home.

OCFS Review Results:

NCDSS adequately investigated the allegations by assessing the child, the child's environment, the caregivers, and collateral contacts. NCDSS documented the specific equipment that was present in the home and on the child, as it related to the adequacy of his care. NCDSS reviewed safe sleep recommendations with BM. NCDSS documented the reason why an interview with the 3-year-old SS was not possible (developmental level) though documented an

assessment of his safety. SC's health condition worsened and he required hospitalization during the investigation, but NCDSS confirmed again his parents were fully meeting his needs.

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

Issue:
Failure to provide notice of report

Summary:
There is no documentation that the BF or MGM were provided with Notice of Existence Letters.

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

Action:
NCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report.

[redacted]

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

There is no known CPS history for the family more than three years prior to the fatality.

Known CPS History Outside of NYS

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

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?	☐	☐	☒	☐

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

In the future, should a child die during an open investigation Nassau CPS will do their due diligence in obtaining all information surrounding the death, along with all collateral contacts as needed.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☒Yes ☐No

Action:	OCFS recommends any time a Child Protective Agency is involved with a family at a time when a child dies, even if the death is not reported to the SCR, the Agency should attempt to gather as much information as possible surrounding the facts and circumstances of the death. As mandated reporters, especially in cases of open CPS investigations, it is essential for workers to gather information to determine whether there is reason to suspect the death was a result of abuse or maltreatment by a caretaker.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No