Child Fatality Report

Report Identification Number: AL-16-023

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

Issue Date: Aug 15, 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	yo- year(s) old

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Montgomery
Gender: Female
Date of Death: 08/27/2016
Initial Date OCFS Notified: 08/27/2016

Presenting Information

On 8/27/16 Montgomery County Department of Social Services(MCDSS) received an SCR report stating that morning the SC was found by SM and(PS in her bed unresponsive. A 911 call was made and EMS and LE responded to the home. EMS personnel attempted to resuscitate the SC but their attempts were unsuccessful. It was reported the SC had no known medical conditions and was considered an otherwise healthy child, making the death suspicious.

Executive Summary

This report involves the death of an eighteen-month-old female child in Montgomery County. On 8/27/16 Montgomery County Department of Social Services (MSDSS) received an SCR report alleging the SC was found unresponsive and the death was being considered suspicious since the child was otherwise a healthy child. At the time of the child's death MCDSS had an open CPS investigation.
Upon notice of the fatality, MCDSS initiated the investigation. MCDSS contacted LE and coordinated investigative actions. LE had already been to the home and taken statements from the SM and PS. LE shared what had occurred at the home upon their arrival and stated that drug paraphernalia and marijuana was found in the MGP's room where the door had been locked and was confiscated. LE accompanied MCDSS to the home were the SM and PS were located. MCDSS spoke the SM and PS who were in the home at the time of the SC's death. The SS was away with the MGP and would be returning home later that evening. MCDSS requested a time line and the activities that occurred over the past few days. From this joint interview with SM and PS it was learned that the child had sustained a bruise to her left forehead which concerned the mother. The child was sleeping a lot and not eating and was brought to the ER on 8/24/17. No serious injuries were found and medication was prescribed for an illness found. Although, at times the SC had shown some signs of improvement she was still not eating and acting like herself. The SM stated she had planned on bringing the child back to the ER on 8/27/16.
Upon his return the SS was observed, spoken too and living arrangements seen and was determined there were no safety concerns.
During the first 48 hours of the fatality investigation MCDSS learned that the PS was residing in the home and listed as OA in the household in a May 2016 child fatality in Montgomery County. MCDSS immediately went to the home of the MGP and addressed this concern with all adults. MCDSS advised the adults it was in their best interest for the PS not to reside in the home. LE and the Medical Examiner were informed of this information. The SM'Smedications and the medications provided to the SC just prior to her death were given to LE. LE requested additional contact with the PS which he initially agreed to but upon obtaining an attorney he was advised not to speak with LE.
MCDSS continued to complete home visits and meet with the mother, MGPs and SS and attempted to secure additional information around the fatality. The family was out of the area for a while. MCDSS had contact information and upon their returned learned the mother was pregnant with the PS child. The family raised the issue that there was no legal basis for the PS to remain out of the home and indicated he would be returning.
On 12/9/16 MCDSS learned from the coroner the SC died as a result of acute pneumonia. On 12/ 22/16 MCDSS unfounded the allegations against the SM. MCDSS offered the SM preventive services which she did not accept. Information on grief counseling was provided.

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?** No
  - **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:
MCDSS maintained ongoing contact with the family and monitored the SS. Additional information regarding SM mental health issues and the PS and PS drug use just prior to the fatality should of been addressed.

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 notes a consultation took place, but no details noted.

Explain:
The case was closed after learning of the cause of death. Additional information from the PS could not be obtained once he obtained an attorney.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	There was insufficient information gathered around the PS and SM drug use, based on their admission they used marijuana the night the SC died and the fact that marijuana was taken by LE from the home the day of the SC's death.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	MCDSS must implement a practice whereby sufficient information is obtained to address the concerns learned during the investigation of the report.
Issue:	Adequacy of Documentation of Safety Assessments

Child Fatality Report

Summary:	MCDSS also did not complete the risk assessment accurately in the PS was not included as the secondary caretaker.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	MCDSS must implement procedures to oversee safety assessments and risk assessment profiles are accurately completed and sufficient information has been obtained to appropriately identify safety and risk factors. .

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/27/2016 **Time of Death:** 09:50 AM

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

County where fatality incident occurred: Montgomery
Was 911 or local emergency number called? Yes
Time of Call: 08:00 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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 10 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were impaired.

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	19 Month(s)
Deceased Child's Household	Grandparent	No Role	Male	52 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	47 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	21 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

MCDSS initially contacted LE to coordinate investigation actions and obtain information around the death. LE responded to the 911 call along with EMS. LE had taken statements from SM and PS but accompanied CPS to the home where the SM and PS were located. The SS was with the MGP in Maine and had not yet returned home. MCDSS jointly spoke with SM and PS and asked for details of the days prior to the SC's death. SM provided most of the initial details; which included that on 8/24/16 SM took SC to ER. SM stated she observed a bruise over SC's right eye when she got up from her nap. SM did not know how the child sustained the bruise but stated the SC at times threw temper tantrums or perhaps she had fallen and hit her head. SM reported ER did not find any head trauma but found SM had illness to her eye, was prescribed medication and instructed to follow-up with her pediatrician the next day. SM stated over the next couple of days the SC was not herself; child slept a lot and wouldn't eat. SM stated on 8/26/16 SC seemed a little better but not herself and SM stated she planned on returning to the ER on 8/27/16. SM stated on 8/26/16 she left the SC with PS while she attended class. She stated the SC was up and drinking fluids but still not eating. PS stated SC remained up a little while and was playing with the dog. PS said he made the SC some lunch but she only drank the liquid in it and a few minutes later he noticed SC had fallen asleep and PS put her in her bed. SC remained asleep until SM returned. At 2:00pm SM said she woke up SC and she seemed a little better but after speaking with MGP the SM was still going to bring SC to ER the following day. SM stated SC was a little fussy when she put her to bed, but SC went to sleep and didn't wake up during the night. On 8/27/16 SM and PS both woke up around 8:00am and SC was not awake yet. Both adults went to SC's room to check on her and found the SC unresponsive. SM and PS provided different details around the position they found the SC in. A 911 call was made and EMS and LE responded to the home. SC was not taken to the hospital. SC was pronounced deceased at home by Coroner and transported to morgue.
MGP and SS returned home later that day. MCDSS met with them and observed the SS. The SS was observed to be healthy and their home found to be appropriate. MGP reported SM had agreed for the MGP to care for the SS until she could do so. MGP provided details of their contact with SM while away and much of the information was the same as what SM had already reported.
LE attended the autopsy and shared with MCDSS that no signs of trauma were found nor was an immediate cause of death determined. LE also shared with MCDSS that while at the home in response to the 911 call marijuana and drug paraphernalia was found on the bed in the SM and PS room.
MCDSS learned within the first few days of the investigation the PS was an OA in the household on another recent fatality in Montgomery County and had babysat for the child the hours prior to her death. MCDSS immediately met with MGP's, PS and SM and discussed the concern and recommended that the PS not reside in the home until the investigation was completed. LE also went to the home and took the SM's medication and the medication given to the SC prior to her death. LE also requested additional meeting with PS when he initially agree to but obtained an attorney who advised not to have any further contact with LE. The went to stay in Maine for a period and MCDSS had contact information for them while gone.
MCDSS maintained contact with the family. Upon their return SM discussed that she was pregnant, the PS was the father of her unborn child and the hardship of not allowing PS to reside inside the home.
On 12/9/16 MCDSS learned the child died from acute pneumonia. On 12/29?16 report was unfounded.
Preventive Services were offered and refused by SM and information on grief counseling was provided.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No
Comments: MCDSS consulted and worked with LE during this investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Montgomery County does not have a approved CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
038402 - Deceased Child, Female, 19 Month(s)	038407 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
038402 - Deceased Child, Female, 19 Month(s)	038407 - Mother, Female, 21 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
Case Planners	☐	☐	☐	☒
Public or Private Child Care	☐	☐	☐	☒
Caretakers / Babysitters	☐	☐	☐	☒
School	☐	☐	☐	☒
Daycare Provider	☐	☐	☐	☒
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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
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:
No seven-day safety assessment was completed. The 24 hour safety assessment must be completed with in 24 hours for an SCR report alleging DOA/Fatality. The seven-day assessment is required in all investigations of SCR reports. The completion of a 24hr safety assessment does not satisfy the requirement to complete a seven-day safety assessment. Both assessments are required.

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 mother's paramour was not identified as a secondary caretaker.

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 safety issues that required the removal of the surviving sibling.				

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 Unavaliable	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? Yes
Explain:

The family was provided with information on counseling services and offered preventive services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
There were no immediate needs identified.

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?	No
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

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)
07/30/2016	Deceased Child, Female, 18 Months	Mother, Male, 21 Years	Inadequate Guardianship		Yes
	Deceased Child, Female, 18 Months	Mother, Male, 21 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Male, 3 Years	Mother, Male, 21 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	Sibling, Male, 3 Years	Mother, Male, 21 Years	Lack of Supervision	Unfounded	
	Deceased Child, Female, 18 Months	Mother, Male, 21 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 3 Years	Mother, Male, 21 Years	Inadequate Guardianship		

Report Summary:
The report alleged the SM leaves the SS and SC alone for 30-60 minutes at a time. Additionally, it was alleged the home was infested with bed bugs.

Determination: Unfounded | **Date of Determination:** 11/16/2015

Basis for Determination:
The determination stated the home was found to be clean and free of bugs. The mother denied she left the children alone or unattended for any length of time. The children were observed and found to be clean and healthy.

OCFS Review Results:
OCFS found MCDSS investigation of this report was in process at the time of the death of the child. The SM left her residence and subsequently moved into the MGP home with her PS, SS and SC. MCDSS had learned there was a prior

issue with bed bugs in the SM's residence and the SC had been brought to the pediatrician for "scabieactions" but was diagnosed with eczema. Case record documents CPS asked SM to take photographs of SC but no indication that occurred or the rash was observed.

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

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
On 8/4/16 MCDSS shared with SC's pediatrician the SC had a rash which SM stated had been diagnosed as eczema covered the child's entire forehead, arms and legs. The pediatrician stated the rash must of gotten worse and he wanted to see SC again. MCDSS did not inform the mother of the pediatrician's request prior to death od SC on 8/27/16.

Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:
MCDSS must implement a protocol whereby child's need for medical attention are addressed in a timely manner.

Issue:
Adequacy of case recording

Summary:
Case record does not document the MCDSS observed the rash, documentation of the extent of the rash or photographed the rash.

Legal Reference:
18 NYCRR 428.5(c)

Action:
MCDSS must take steps to make sure case notes reflect observation of children and what was seen.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/10/2014	Sibling, Male, 18 Months	Mother's Partner, Male, 23 Years	Excessive Corporal Punishment	Indicated	Yes
	Sibling, Male, 18 Months	Mother's Partner, Male, 23 Years	Lacerations / Bruises / Welts	Indicated	
	Sibling, Male, 18 Months	Mother's Partner, Male, 23 Years	Inadequate Guardianship	Indicated	

Report Summary:
The PS physically assaulted 18-month-old SS and SM. The SS sustained bruising to his back and buttocks and a laceration to the corner of his right eye. the SS had bruises in various stages of healing. It was reported the PS beat the SS with broomstick or another object. The SM sustained bruising to her throat from being choked and bruises to both arms from being restrained.

Determination: Indicated | **Date of Determination:** 01/13/2015

Basis for Determination:
The SS was found to have bruising in different stages of healing and a laceration to his right eye. The PS was charged with Reckless Assault and did serve jail time because of the charges. An OOP was issued. It was found SM acted appropriately by calling LE and removing herself from the situation.

OCFS Review Results:
OCFS found that MCDSS contacted collateral sources which identified concerns around SM's care of the SS including drug use, the people she leaves the SS with and a prior CPS history in Florida. Allegations identified were not fully

explored with mother. Mother denied using drugs but positive for marijuana during her pregnancy at the time. Caretakers and their appropriateness were not explored. The seven-day safety assessment identified the child was not completed accurately. controlling interventions, PS arrested and SM obtaining OOP are controlling interventions. The SS would not be safe without those interventions.

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

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
MCDSS did not completely investigate allegations identified by collateral contacts during the investigation. MCDSS did not contact a pertinent collateral contact.
Legal Reference:
SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:
MCDSS must develop protocols to make sure concerns identified during an investigation are appropriately and completely addressed. The protocol must include insurance that pertinent collateral sources are contacted

Issue:
Timely/Adequate Seven Day Assessment
Summary:
MCDSS did not accurately complete the seven-day safety assessment.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
MCDSS must develop a protocol to make sure seven day seven assessments are accurately completed.

[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 on the subject child or her surviving sibling.

Known CPS History Outside of NYS

There is no known CPS history outside of New York 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

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