Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-20-013

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

Issue Date: Jul 28, 2020

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Ulster
Gender: Female
Date of Death: 04/18/2020
Initial Date OCFS Notified: 04/19/2020

Presenting Information

On 4/18/20, the mother and the father left the subject child alone, unsupervised in the bathtub for approximately 20 minutes. As a result, the child drowned and was found unresponsive in the bathtub. One of the parents began CPR. It was unknown if it was the mother or the father. One of the parents called 911 at 6:00PM and the police responded at 6:04PM. When police arrived, the mother, father and the subject child were in the bedroom. The subject child was on the floor in a supine position, without any clothes and appeared wet. The subject child had no visible injuries. Police initiated CPR while they waited for EMS. EMS arrived shortly after police and transported the subject child to the hospital where she was pronounced deceased at 6:36PM. The mother and father failed to provide appropriate supervision for the subject child resulting in her death. The siblings were present and had unknown roles.

Executive Summary

This fatality report concerns the death of the 6-month-old female subject child that occurred on 4/18/20. A report was made to the SCR on the same date concerning the child's death, with allegations of Inadequate Guardianship, Lack of Supervision and DOA/Fatality against the mother and father of the subject child. There were three surviving siblings ages, 1, 7, and 8, who Ulster County Department of Social Services (UCDSS) determined were not safe remaining in their parents' care. The children were removed and subsequently placed in a foster home

UCDSS coordinated investigative efforts with law enforcement, the Child Advocacy Center and the District Attorney's Office. At the time this report was written, law enforcement had charged the mother and father with criminally negligent homicide related to the death of the subject child. Law enforcement determined through several timed water level tests that the subject child was left unsupervised in the bathtub with the shower water on for a period of 20-38 minutes before being found unresponsive by the parents. Law enforcement reported they were at the home earlier in the day for concerns of a domestic incident. UCDSS requested the autopsy report from the Medical Examiner's Office; the cause of death was drowning and the manner was accidental.

The investigation revealed that on the day of the fatality the mother, father, subject child, siblings and a family friend were at the home. The subject child had soiled herself and the mother and father argued about giving the child a bath to get clean. The father placed the subject child in the bath with the shower water running. The mother and father reported this was how they typically bathed their children and it was never a problem in the past. The child was left unsupervised while the mother and father tended to food burning downstairs. The father also took a phone call and smoked a cigarette at that time. The parents reported the child being left alone for a period of five seconds to ten minutes. The mother returned to find the child floating and unresponsive. The family friend called 911 and life saving efforts were made by the mother and friend until law enforcement arrived and took over CPR. Emergency medical services arrived and transported the subject child to the hospital where she was pronounced deceased at 6:36PM.

The siblings were initially placed in foster homes and then relocated to relative foster care placement. The siblings remained in relative foster care at case closure. The father had additional children whom resided with their mother. UCDSS contacted the mother via telephone to assess the safety of those children in her care. It was determined the father had contact with these children outside of the home. The mother reported no concerns for her children while visiting with the father.

The mother and father of the subject child participated in supervised visits with their surviving children. Bereavement

services and burial assistance were offered to the mother and father. The mother was provided a referral to the Child Advocacy Center. The siblings were provided with a referral to mental health services.

UCDSS gathered information through collateral and casework contacts and appropriately indicated the allegations of Inadequate Guardianship, Lack of Supervision and DOA/Fatality against the mother and father. At case closure there were pending severe abuse petitions against the parents. The investigation was closed on 6/18/20 and the case remained open with foster care services.

PIP Requirement

UCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the UCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, UCDSS will review the plan and revise as needed to address ongoing concerns.

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:

UCDSS conducted thorough interviews of the parents and adequately assessed for the safety of the surviving siblings. The fatality reports, safety assessments and risk assessment were completed timely and accurately. UCDSS assessed the family for needed services and offered them to the mother and father. UCDSS contacted several collaterals and first responders to make an appropriate determination.

Was the decision to close the case appropriate? N/A

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:

A family services stage was opened and the siblings remained in relative foster care at the closure of the investigation.

Required Actions Related to the Fatality

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

Issue:	Review of CPS History
Summary:	UCDSS did not document a history check was conducted until approximately 7 weeks after the receipt of the SCR report.
Legal Reference:	18 NYCRR 432.2(b)(3)(i)
Action:	Within 1 business day of a report, UCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, LDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.
Issue:	Failure to provide notice of report
Summary:	It was not documented that notification of existence letters were sent to the mother and father until approximately 7 weeks after the receipt of the SCR report.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	UCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/18/2020 **Time of Death:** Unknown

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

County where fatality incident occurred: Ulster
Was 911 or local emergency number called? Yes
Time of Call: 06:00 PM
Did EMS 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: Bathing

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 20 Minutes
At time of incident supervisor was:

☐ Drug Impaired ☒ Absent
☐ Alcohol Impaired ☐ Asleep

☒ Distracted
☐ Impaired by disability
☐ 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	6 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)

LDSS Response

Upon receipt of the SCR report on 4/18/20, UCDSS initiated their investigation and coordinated efforts with LE, notified the CAC and spoke to the source. UCDSS assessed the safety of the three surviving siblings ages, 1, 7, and 8, and determined they were not safe remaining in their parents' care. The siblings were removed and subsequently placed in FC.

UCDSS gathered information from first responders. Upon arrival to the scene, LE observed the SC in the parent's bedroom, unclothed and wet, with the SM performing adult CPR. LE took over lifesaving efforts until Mobile Life arrived and transported the SC to the hospital where she was pronounced deceased at 6:36PM. A death scene analysis was performed, and it was determined that the bathtub took approximately 20- 38 minutes to fill to the 10 inches it was discovered at when first responders arrived. LE found that there was criminality related to the death of the SC and both parents were charged with criminally negligent homicide. In addition, the SF was charged with criminal contempt for violation of an OP due to a domestic incident that occurred at the residence a few hours prior to the fatality.

The SM reported that she, the siblings, SC, SF and a family friend were home at the time of the incident. The SM said she and the SF were having a disagreement and denied this became physical as reported by collaterals. During that time, the SC had defecated, and the SF insisted she be given a bath. The SM and SF placed the SC in the bathtub with the shower running. The parents smelled food burning downstairs and the went to tend to it. While downstairs, the SF took a phone call. The SM reported she returned 5-10 minutes later to find the SC floating and unresponsive. The SF reported that he put the SC in the shower after she had soiled herself. The SC was left alone while he went to check on food that he believed was burning downstairs, smoked a cigarette and took a phone call from the PGF. The SF reported the child was left alone for only 5 seconds.

The parents reported it was typical for them to place their CHN in the bathtub with the water running and it had never been a problem in the past. UCDSS questioned the SM about drug and alcohol use which she denied. The SM reported the SF smoked marijuana, but it was unknown if he had done so the day of the fatality.

UCDSS contacted all necessary collaterals. A friend was at the home at the day of the fatality and reported the parents were fighting frequently throughout the day and the SF had struck the SM. The friend denied the parents were fighting at the time of the incident. While the SC was in the bath, the SF had asked the friend for a cigarette. The friend heard the SM

scream and watched as the SM picked the SC out of the tub filled with water. The friend assisted with CPR until first responders arrived.

The 8yo and 7yo siblings were interviewed at the CAC. The 8yo reported hearing the SM and SF fighting throughout the day and while the SC was in the bath. The 8yo reported that he witnessed the SF performing CPR on the SC. The 7yo minimally engaged in the interview and provided no details related to the fatality.

UCDSS had several contacts with the CHN and parents throughout the investigation. UCDSS offered the parents grief counseling and burial assistance and a referral was made to the CAC for the SM. Referrals for MH were made for the siblings. The CPS investigation was IND and remained open for foster care services.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Forensic Pathologist

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: The case record contained documentation that the case was reviewed by an MDT. In addition, there is documentation of consultation with law enforcement related to the fatality.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Ulster County Department of Social Services does not have an OCFS approved CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053981 - Deceased Child, Female, 6 Month(s)	053983 - Father, Male, 26 Year(s)	DOA / Fatality	Substantiated
053981 - Deceased Child, Female, 6 Month(s)	053983 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
053981 - Deceased Child, Female, 6 Month(s)	053983 - Father, Male, 26 Year(s)	Lack of Supervision	Substantiated
053981 - Deceased Child, Female, 6 Month(s)	053982 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
053981 - Deceased Child, Female, 6 Month(s)	053982 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
053981 - Deceased Child, Female, 6 Month(s)	053982 - Mother, Female, 29 Year(s)	Lack of Supervision	Substantiated

CPS Fatality Casework/Investigative Activities

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

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

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐

During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☒	☐	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: UCDSS conducted a removal without the mother's consent and with the father's consent within 24 hours of the fatality. UCDSS then requested a continued removal at Family Court, which was granted by the Judge.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☒Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
04/21/2020	There was not a fact finding	There was not a disposition
Respondent:	053982 Mother Female 29 Year(s)	
Comments:	The Judge ordered continuation of placement in foster care and that UCDSS explore relative foster care options for the siblings.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
04/21/2020	There was not a fact finding	There was not a disposition
Respondent:	053983 Father Male 26 Year(s)	
Comments:	The Judge ordered continuation of placement in foster care and that UCDSS explore relative foster care options for the siblings.	

Criminal Charge: Criminally negligent homicide	**Degree:** NA		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	Mother and Father	Pending	Pending
Comments:	The mother and father were charged with criminally negligent homicide in relation to the fatality of their child.		

Have any Orders of Protection been issued? Yes	
From: 04/21/2020	**To:** Unknown
Explain: There was an OP issued against the mother and father in relation to the surviving siblings which allowed for supervised visitation.	

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☒	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☒	☐	☐	☐	☐	☐	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☒	☐	☐	☐	☐	☐	☐
Early Intervention	☐	☐	☐	☒	☐	☐	☐
Alcohol/Substance abuse	☐	☐	☐	☒	☐	☐	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☒	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The siblings were removed and placed in relative foster care where they will receive services. The parents were offered burial assistance and grief counseling. The mother was referred to the CAC Family Advocate and mental health counseling.

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 surviving siblings remained in foster care and a referral for mental health services had been made, which was being monitored in the family services stage.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered grief counseling and burial assistance. The mother was referred to the CAC Family Advocate. The mother was enrolled in therapy at case closure. It is unknown if the father was enrolled in services.

History Prior to the Fatality

Child Information

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

Infants Under One Year Old

During pregnancy, mother:
- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:
- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/06/2019	Sibling, Male, 7 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report received alleged that on 10/6/19, the father and the mother engaged in a verbal altercation that turned physical when the father threw an object at the television and broke it. The father then broke the window when he punched it. The father then grabbed a large kitchen knife and held it to the mother's pregnant stomach and threatened to kill her. The father then turned to the then 7-year-old sibling, who witnessed the incident, and threatened to kill him.

Report Determination: Unfounded | **Date of Determination:** 01/11/2020

Basis for Determination:
UCDSS determined that there was no credible evidence to indicate the allegations of IG against the father. The 7-year-old sibling was interviewed and reported that he did not witness any physical altercations and nobody made threats of harm to him. The mother and father reported they engaged in a verbal argument and the mother attempted to leave, which required a knife to open the broken door handle. The father grabbed the knife from the mother resulting in a cut to his hand.

OCFS Review Results:
UCDSS conducted multiple home visits and assessed for safety within 24 hours of the SCR report. OCDSS did not complete the 7-day safety assessment tool until more than 2 weeks after the SCR report and safety concerns were not accurately documented. The RAP was completed; however, was inaccurate. The FA of one of the siblings was not added to the investigation or notified of the report. The SC was born during the investigation and safe sleep guidelines were not provided to the parents. There were multiple instances of non contemporaneous progress notes. The determination was not appropriate.

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

Issue:
Failure to provide safe sleep education/information
Summary:
The subject child was born during this CPS investigation and it is not documented that UCDSS provided the parents with information on safe sleep guidelines.
Legal Reference:
13-OCFS-ADM-02
Action:
13-OCFS-ADM-02 notes a review and assessment of a child’s sleeping environment must be documented, and immediately addressed if assessed to be unsafe. In all CPS investigations with an infant in the home, caregivers must be provided with safe sleep information.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Despite having regular contact with the child, the father of the then 7-year-old sibling was not added to the investigation, made aware of the SCR report in writing or interviewed regarding the SCR report.
Legal Reference:
432.1 (o)
Action:
UCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Timely/Adequate Seven Day Assessment
Summary:

The 7-day safety assessment was not completed within the required time frame and was inaccurate. Due to the history of CPS investigations related to the family with the same concerns, safety factor 1 would have been appropriate to include, in addition to the other safety factors identified by UCDSS. The parent/caretaker actions tab was not completed.

Legal Reference:

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

Action:

UCDSS will document and approve all assessments and accurately reflect the safety factors that are present within the required time frame.

Issue:

Appropriateness of allegation determination

Summary:

UCDSS determined the allegations of IG were unfounded against the FA, as the maltreated child was not witness to the events and therefore was not impacted. The FA violated an OP, which resulted in an altercation with the mother while the child was home. The violation of the OP and the information provided by the child during his interview was sufficient to indicate the allegations against the FA.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

UCDSS will refer to the CPS Program Manual and/or consult with the Westchester Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The mother reported a mental health diagnosis during an interview and this was not accurately reflected in the Risk Assessment Profile.

Legal Reference:

18 NYCRR 432.2(d)

Action:

UCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/26/2019	Sibling, Male, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Internal Injuries	Far-Closed	

Report Summary:

An SCR report received alleged that on 3/26/19, the mother got angry with the then 5-year-old child because he was too slow getting ready for school. The mother hit the child in the face with excessive force and caused the caused the child to sustain a bloody nose. The role of the then 6-year-old child was unknown.

OCFS Review Results:

UCDSS completed the CPS FAR case timely and the FLAG was completely accurately. The notes indicated that CPS FAR tools were used to engage the children during casework contacts. The notes indicated that the children spent time at their father's residence and there was no visit made to assess the safety of the children at his residence. The notes

indicated that safe sleep was verified but didn't indicate that the mother and father were provided information on safe sleep guidelines.

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

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible

Summary:
The mother reported that the father had consistent contact with the then 6-year-old and 5-year-old siblings and UCDSS did not engage the father in the FAR process.

Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)

Action:
The child protective service must verbally inform the parent, guardian or other person legally responsible about the areas of concern that triggered the report and explain that they must explore those concerns and assess the safety of any child named in the report or living in the household.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/09/2019	Sibling, Male, 6 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Male, 5 Years	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 4 Months	Father, Male, 24 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 6 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 4 Months	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received alleged that on an ongoing basis the FA was physically violent towards the MO in the presence of the then 6yo, 5yo and 4mo surviving siblings. An incident occurred on 1/8/19, when the FA dragged the MO by the hair across the floor in the presence of the children. A week prior to that, the FA assaulted the MO and missed and scratched the 4mo on the face, which caused a superficial mark. About 1-2 months before the SCR report, the FA assaulted the MO and then left the home. The MO followed the FA and left the children unsupervised and unattended for at least 45 minutes with food in the oven. The MO was aware the children required direct supervision due to their ages.

Report Determination: Indicated | **Date of Determination:** 02/14/2019

Basis for Determination:
UCDSS determined there was some credible evidence to indicate the allegations of IG and LSUP against the father. The father went to the family home despite there being an OP and altercations ensued in the presence of the children. The father was arrested and remained in jail at case closure. UCDSS unfounded the allegations of IG and LSUP against the mother, finding that the there was no credible evidence to support that the mother left the children unattended.

OCFS Review Results:
UCDSS thoroughly investigated the allegations and gathered information from appropriate collaterals. They spoke to the source, completed a history check and completed the notes, safety assessments and risk assessment timely. UCDSS did not identify appropriate risk and safety factors. There were multiple instances of the OP being violated, which resulted in the children being exposed to domestic violence, and no evidence of a legal consultation for possible family court involvement. Despite ongoing concerns of DV there were no DV services offered. The father of the then 6yo sibling was not interviewed despite having regular contact with the child

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

Issue:

Appropriateness of allegation determination

Summary:

UCDSS justified unfounding the allegation of IG against the MO by stating there was no evidence the children were ever left unattended; however, during the investigation, it was evident the MO was aware of the OP in place and reported she welcomed the FA into the home despite it. The MO had knowledge that this has lead to incidents of violence and put the children at imminent risk of harm.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

UCDSS will refer to the CPS Program Manual and/or consult with the Westchest Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Issue:

Assessment as to need for Family Court Action

Summary:

Despite there being an OP in place against the father, there continued to be incidents of DV while the children were home, putting them at risk of harm. There is no documentation that due to ongoing DV concerns, CPS reports, and the mother's unwillingness to recognize the seriousness of the concerns, that UCDSS consulted with their legal department about the need to involve family court.

Legal Reference:

SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:

UCDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

Issue:

Failure to offer services

Summary:

The mother reported the father had grabbed her by the back of the neck and shook her, in addition to several verbal disputes. UCDSS documented numerous domestic incident reports involving domestic violence. Despite the information gathered during the investigation, UCDSS failed to offer the mother domestic violence services.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, UCDSS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/10/2018	Sibling, Male, 6 Years	Father, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:

An SCR report received alleged that the father wanted the then 6-year-old child to leave the room. The father cursed at the child and pushed him to the floor with excessive force. The adults in the home smoked marijuana and drank alcohol. It was unknown if they used to the point of impairment. The roles of the mother, other adults and two other children were unknown.

Report Determination: Unfounded | **Date of Determination:** 03/06/2019

Basis for Determination:
UCDSS conducted several home visits throughout the investigation and did not observe the adults to be under the influence of drugs or alcohol. The children were interviewed and no disclosures were made regarding the allegations. Collaterals were spoken to who reported no safety concerns for the children.

OCFS Review Results:
UCDSS assessed the safety of the children within 24 hours and determined there to be no immediate safety concerns for them. UCDSS completed several home visits throughout the investigation and obtained information from collaterals. UCDSS inquired with the mother about appropriate services including parenting, mental health and domestic violence.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/18/2018	Sibling, Male, 1 Months	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 1 Months	Father, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received alleged that on 10/18/18, the father pushed the mother on top of the then 6-week-old who was sitting in the car seat. There were no visible injuries to the child but he was crying. The mother threw items on the floor in the presence of the child.

Report Determination: Unfounded **Date of Determination:** 12/17/2018

Basis for Determination:
UCDSS determined that there was a fight that occurred between the father and the mother, in which the mother was pushed. The older children were not present when this occurred and UCDSS found the then 1-month-old child was unaffected by the parent's actions.

OCFS Review Results:
UCDSS conducted a timely investigation. They sent timely notification letters, interviewed appropriate collaterals, conducted a history check and spoke to the source. UCDSS did assess for safety within the first 7 days of the SCR report; however, failed to complete the 7-day safety assessment tool in connections. It was determined that the father, whom was a subject on the report, had multiple other children whom he had contact with, and there was no exploration of what this contact consisted of and no notification to the children's mothers of the CPS investigation. UCDSS did not offer the mother appropriate services.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-day safety assessment tool was completed 9 days after the receipt of the SCR report. UCDSS identified safety factors and a safety decision; however, the parent/caretaker actions tab was not completed.

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

Action:
UCDSS will accurately document and approve all safety assessments within the required timeframe

Issue:
Failure to offer services

Summary:
UCDSS received information from LE that their have been prior domestic incidents with the FA that appeared to be worsening. The MO reported there was yelling and pushing between she and the FA. The then 6yo and 5yo siblings

reported that the FA yelled at and pushed their MO and had thrown a chair. Despite this information, it is not documented that UCDSS offered services to the MO and FA.

Legal Reference:

SSL §424(10);18 NYCRR 432.3(p)

Action:

Based on the investigation and evaluation conducted, UCDSS will offer to the family such services for its acceptance or refusal as appear appropriate for a child, family, or both.

Issue:

Pre-Determination/Assessment of Current Safety/Risk

Summary:

The case was pre-determined to the assessment of safety and risk, due to the fact that the father reported having additional children, and UCDSS failed to inquire about the father's contact with them and assess their safety.

Legal Reference:

18 NYCRR 432.2 (b)(3)(iii)(b)

Action:

UCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.

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

1/18/16-3/18/16 the father had one indicated case with allegations of Inadequate Guardianship regarding a half sibling whom resides in another home.

12/31/15-2/9/16 the mother had a CPS FAR case with concerns of discipline related to the surviving siblings.

Known CPS History Outside of NYS

The family had no known CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: There had been an OP in place against the father in relation to the mother since approximately December 2018. The OP had ranged from a full stay away to a refrain from, which was the status of the OP at the time of the fatality.	

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