Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-19-004

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

Issue Date: Jul 01, 2019

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: 3 year(s)
Jurisdiction: Orange
Gender: Male
Date of Death: 02/08/2019
Initial Date OCFS Notified: 02/08/2019

Presenting Information

An SCR report alleged on 2/8/19, the 3-year-old subject child was lying on his bed for an unknown amount of time while in the care of both parents. Around 7:20 PM, one of the parents checked on the child while he was sleeping. At approximately 8:20 PM, both parents checked on him and found him unresponsive. The parents called 911, and EMS and police arrived at the home. The child passed away at an unknown time. He was otherwise healthy and there was no plausible explanation for the cause of his death. It was further noted the child was sick with a stomach bug and prescribed an antibiotic four to five days prior, but it was unknown if the illness contributed to the death.

Executive Summary

This fatality report concerns a 3-year-old child whose death was investigated by the Orange County Department of Social Services (OCDSS) and the Newburgh Police Department. An SCR report made on the date of the fatality alleged the parents were responsible for the care of the otherwise healthy child and provided no plausible explanation for his death.

The child was declared deceased shortly after arrival at the hospital on 2/8/19. An autopsy was conducted by a medical examiner, who concluded the manner of death was natural and the cause was “complications of mixed viral infection including Influenza A H3.”

The investigation revealed the mother and father took the child to the pediatrician the day before his death as he was exhibiting symptoms of illness. The child was given a rapid test for the Influenza virus and he was negative for Types A and B. He was diagnosed with an infection and sent home with a prescription for an antibiotic. The parents administered two doses of the medication over the course of the next 24 hours as directed. While he was resting in bed the evening of 2/8/19, the mother checked on the child and found him unresponsive. The parents called 911 and emergency medical services arrived, who administered life-saving efforts and transported the child to the hospital. Revival efforts by hospital staff were unsuccessful, and the child was pronounced deceased.

Before the cause of death was known, OCDSS assessed the safety of the two surviving siblings, ages 1 and 5. Safety was assessed in the first 24 hours of the investigation by observing the children and their home environment, having them medically evaluated at the hospital, and interviewing the parents, law enforcement, and medical staff. There were no immediate safety concerns for the siblings, and they were deemed medically well. The parents were also medically evaluated to rule out infectious illnesses; none of the surviving family members had acute illnesses.

During the investigation and prior to a confirmed cause of death, OCDSS and law enforcement convened to discuss the facts gathered and it was noted no criminal charges had been filed. It was not apparent there was a plan to file any charges, and the record did not reflect any arrests were made in connection to the fatality.

OCDSS addressed other areas of child welfare concern, which included the family’s poor hygiene and unkempt home, also known to be of historical CPS concern. OCDSS worked together with the family, school, and medical providers to see that the parents were providing the surviving siblings with necessary healthcare services and meeting their developmental needs. OCDSS appropriately offered voluntary preventive services on multiple occasions, specific to the needs of the family. Though the parents were initially receptive to some services, all services were eventually declined, including those offered in relation to the fatality. The family shared their needs were met with the assistance of familial resources, with whom OCDSS communicated and confirmed to be of reliable support, as well as self-sought therapeutic

services for the mother and eldest sibling to manage grief.

OCDSS concluded there was no credible evidence to substantiate the allegations against the parents, and the case was unfounded. After all casework activity was completed and productive conversations were held with the family members and persons regularly involved with the family, the investigation was closed.

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:
Safety assessments were timely and appropriate. The determination of allegations was appropriate given the supportive evidence in the case.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
The decision to close the case was appropriate. There was an abundance of supervisory consultation in the documentation.

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: 02/08/2019 **Time of Death:** 08:51 PM

Time of fatal incident, if different than time of death: 08:00 PM

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: 08:19 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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 45 Minutes
At time of incident supervisor was: Not 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	Male	3 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)

LDSS Response

OCDSS promptly initiated an investigation by coordinating amongst agency staff, police, and the medical examiner's office. The agencies jointly responded to the hospital. OCDSS interviewed the parents together, alongside the medical examiner's senior investigator. OCDSS learned police did not find criminal concern, so OCDSS provided notification to the DA.

During interviews, the mother and father reported the child was sent home early from school on 2/6/19. Once home, he had a low-grade fever. The father called the pediatrician and an appointment was scheduled for the following morning. The mother gave the child an over-the-counter analgesic and a bath. He awoke the next day with diarrhea and vomited. The pediatrician diagnosed him with a bacterial infection. The parents said he was also diagnosed with a stomach bug after

testing negative for Influenza. Though symptoms of vomiting were noted in the medical records received by OCDSS, the additional diagnosis was not recorded. A drug was prescribed to take twice a day, and the Dr. said to give him plenty of fluids. The parents administered a dose of the medication that night and again the next morning.

The parents said the next day, 2/8/19, the child seemed better, but vomited in the morning. All three children were home that day with the parents. The child ate a small amount of food, napped, and drank juices throughout the day. The mother brought him to bed around 5:30 PM; shortly thereafter, he fell asleep. She checked on him twice, noting he was breathing both times. She checked on him again around 8 PM and noticed he was warm but unresponsive. She told her husband to call 911 and began administering CPR as instructed by the operator. When EMS arrived, the child had no pulse. Resuscitative efforts were continued at the hospital, but he was unable to be revived.

After the cause of death was known and all medical information was gathered, there was no evidence any actions or inactions contributed to the child's death. The parents had sought prompt medical attention when the child initially fell ill and when found in distress. The child's immunization records revealed he had not been immunized for Influenza. The parents had deferred the immunization nearly one year prior. Despite this, there was no medical conclusion that a vaccine would have prevented the outcome.

The mother reported she brought the youngest sibling to the hospital the day after the fatality for a cough and fever; she noted he tested positive for an illness and was given medication. OCDSS spoke with her about following the same prompt medical attention if the other sibling exhibited symptoms. The siblings were noted to be well at subsequent home visits. Despite efforts made to interview the elder sibling, one was not successful due to her developmental delays.

There was no concern noted for either parent being under the influence of drugs or alcohol around the time of the fatality. The parents were medically evaluated after the death and no concerns were revealed. OCDSS asked the parents about their own health history and medications, which were documented and described as being kept in safe locations.

First responders had no concerns for the condition of the home; it was relayed their time there was brief and focused on emergency care. OCDSS knew hygiene and home cleanliness was a common historical concern. Though similar issues were present during this investigation, there were no hazards or safety concerns for the children. OCDSS addressed this with the parents and documented improvements in follow up visits. OCDSS worked with the family and providers to meet specified needs of a sibling. OCDSS found the family worked to mitigate issues brought to their attention and with assistance from relatives. OCDSS offered several services and support to the family and had many productive conversations. Though the parents initially requested and were receptive to services, eventually all offers were declined.

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: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The fatality was reviewed twice during the open investigation by Orange County's CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050314 - Deceased Child, Male, 3 Year(s)	050313 - Father, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
050314 - Deceased Child, Male, 3 Year(s)	050313 - Father, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
050314 - Deceased Child, Male, 3 Year(s)	050315 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
050314 - Deceased Child, Male, 3 Year(s)	050315 - Mother, Female, 24 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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

Though efforts were made to engage the eldest sibling in an interview, one was not successful due to the child's developmental delays. Pertinent information about both surviving children was gathered from relevant sources.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐

Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
All necessary services were offered but declined by the family. There were not sufficient grounds to compel services. The family noted the mother and eldest sibling were receiving their own counseling services.

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 for any reason during this investigation.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After 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:
Services were described and offered to the family on more than one occasion based on the identified areas of need. The Special Assistance Trauma Unit was referred and they reached out to the family; initially they were receptive, but services were later declined. Improving Families (a preventive service) and a family educational specialist were offered, but such services were also declined.

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:
Though all services offered by OCDSS were declined, the eldest sibling began receiving counseling in school. OCDSS also recommended the children be medically evaluated at the hospital following the fatality to rule out any acute illnesses, which was completed.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Though all services offered by OCDSS were declined, the mother shared she enrolled in counseling in response to her grief. OCDSS also recommended the parents be medically evaluated at the hospital following the fatality to rule out any acute illnesses, which was completed.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? 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)	Allegation Outcome	Compliance Issue(s)
08/09/2018	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 3 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 3 Years	Father, Male, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 3 Years	Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Years	Father, Male, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 3 Years	Father, Male, 28 Years	Lack of Supervision	Unsubstantiated	

Deceased Child, Male, 3 Years	Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 1 Years	Father, Male, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 1 Years	Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 1 Years	Father, Male, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 1 Years	Father, Male, 28 Years	Lack of Supervision	Unsubstantiated
Sibling, Male, 1 Years	Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 4 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 4 Years	Mother, Female, 24 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 4 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 4 Years	Mother, Female, 24 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Female, 4 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Female, 4 Years	Father, Male, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Female, 4 Years	Father, Male, 28 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 4 Years	Father, Male, 28 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Female, 4 Years	Father, Male, 28 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 4 Years	Father, Male, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
An SCR report alleged the parents smoked marijuana to impairment daily in the presence of the children. They frequently drove under the influence with them and left marijuana accessible in the car, and failed to regularly feed them. The home posed a health hazard, with garbage, feces, and dirty clothes throughout. The children had poor hygiene. The parents were physically abusive and beat them regularly with hands or objects, leaving bruises. A subsequent report made on 8/15/18 had similar allegations and also alleged inadequate supervision, at times leaving the kids inside while they used drugs outside. The investigation was conducted by Ulster County Department of Social Services (UCDSS).

Report Determination: Unfounded | **Date of Determination:** 09/14/2018

Basis for Determination:
UCDSS immediately responded to both SCR reports in the evening hours on the dates the reports were made to address the alleged concerns. UCDSS found at each contact (several of which were unannounced) that the parents were sober, noting detailed observations in the progress notes; further, the parents denied drug use. The parents also denied physical discipline, and the children presented without marks, bruises, injuries, or poor hygiene. Supervision was addressed and the parents denied what was alleged, and UCDSS did not find evidence to substantiate this as a concern.

OCFS Review Results:
UCDSS conducted a complete investigation, though a review of CPS history was not noted within the required timeframe. UCDSS saw the family on many occasions and maintained a positive rapport with the parents and children despite historical challenges. Observations, including those pertaining to the allegations, were descriptive and detailed. As in the recently closed investigation, UCDSS discussed the parents' feelings on having the youngest sibling evaluated for developmental delays given both the subject child's and elder sibling's prognoses, a service which the parents declined.

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

Issue:
Review of CPS History

Summary:
Although it appeared a review of history was done based on wording in the 7-Day Safety Assessment, there was no documentation such review was completed within the required timeframe.

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

Action:
Within 1 business day, UCDSS will review SCR records pertaining to all prior reports involving a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report, including legally sealed unfounded reports. Within 5 business days, UCDSS will review and document all CPS record(s) that apply to the prior reports.

PIP Requirement:
Ulster County Department of Social Services (UCDSS) will submit a PIP to the Spring Valley Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/10/2018	Sibling, Male, 7 Months	Father, Male, 27 Years	Lack of Supervision	Unsubstantiated	Yes

Report Summary:
An SCR report alleged that on the date of the report, the father left the youngest sibling, who was under the age of 1, home alone and unattended in his crib for at least 15 minutes. The child was said to have no injuries. The report noted it took 15 minutes for the father to arrive home, and when he did, the child was observed to have been in the home while he had not been there. It was further noted the room where the family resided was dirty, but absent of any safety or health concerns for the child. The investigation was conducted by UCDSS as the family resided in Ulster County.

Report Determination: Unfounded | **Date of Determination:** 04/12/2018

Basis for Determination:
The parents denied the allegations, and UCDSS made several home visits, finding all three children appropriately supervised at each contact. UCDSS made collateral contacts to gather additional information concerning the allegations, finding no evidence of insufficient child supervision. UCDSS connected the family with Early Intervention services as previously referred by the pediatrician, and aided with communication between the family, providers, and school district.

OCFS Review Results:
UCDSS made referrals for services and offered additional support to the parents, though the parents utilized their own familial resources. UCDSS monitored the parents' follow through with meeting the children's needs. UCDSS documented their engagement with the family at each contact, which appeared to positively influence information-gathering and assistance to the family. The family may have benefitted from an educational advocate to assist the parents

through processes, though this service was not discussed. There was no documentation a CPS history check was completed.

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

Issue:
Review of CPS History

Summary:
There was no documentation a CPS history check was completed.

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

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Within 1 business day, UCDSS will review SCR records pertaining to all prior reports involving a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report, including legally sealed unfounded reports. Within 5 business days, UCDSS will review and document all CPS record(s) that apply to the prior reports.

PIP Requirement:
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Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/06/2017	Deceased Child, Male, 1 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 1 Years	Mother, Female, 22 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 1 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Years	Father, Male, 26 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Mother, Female, 22 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 26 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report alleged the father was leaving the subject child and his sibling (then ages 1 and 3) unsupervised at the home during the night when he went to pick up the mother from work. The mother was aware of this, and continued to allow it to happen. The investigation was conducted by Ulster County Department of Social Services as the family resided in Ulster County.

Report Determination: Unfounded | **Date of Determination:** 05/04/2017

Basis for Determination:
UCDSS addressed the allegations with the parents, who denied leaving the children home alone at any time.

Unannounced visits were conducted and revealed the children were supervised at those times. With the parents, UCDSS addressed additional concerns that arose during the investigation, such as safety hazards in the home, the home's overall cleanliness, and meeting the children's routine medical needs. UCDSS found that subsequent visits revealed no safety concerns warranting a safety plan or further intervention. Advice and information on services was given to the parents.

OCFS Review Results:
In addition to the allegations, UCDSS promptly addressed other child welfare concerns as they arose such as safety hazards to the young children found at the initial home visit and necessary follow up appointments with the pediatrician. The condition of the home was addressed at each subsequent home visit. Many discussions were held to educate the parents on how to best meet the needs of their children, and UCDSS helped relay information from the doctor. An educational/advocacy service for persons with disabilities was offered in response to the assessment that the parents might have benefitted from the service, though it did not appear to be used. A review of CPS history was not documented.

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

Issue:
Review of CPS History

Summary:
There was no documentation a CPS history check was completed.

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

Action:
Within 1 business day, UCDSS will review SCR records pertaining to all prior reports involving a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report, including legally sealed unfounded reports. Within 5 business days, UCDSS will review and document all CPS record(s) that apply to the prior reports.

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

On 6/6/14, Ulster County Department of Social Services' investigation of an SCR report dated 5/12/14 was unfounded. Inadequate guardianship and lack of medical care had been alleged against both parents concerning the eldest sibling, then 8 months old.

Known CPS History Outside of NYS

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

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