Child Fatality Report

Report Identification Number: SV-18-023

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

Issue Date: Jul 09, 2018

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: 10 month(s)
Jurisdiction: Ulster
Gender: Female
Date of Death: 03/04/2017
Initial Date OCFS Notified: 04/25/2018

Presenting Information

On 2/16/2018, Ulster County Department of Social Services (UCDSS) spoke with the Spring Valley Regional Office by phone, notifying them that they recently learned the SC, a medically fragile child, died while a CPS-FAR case was open in 2017. The fact that the SC had passed away during that previously open case was unknown to UCDSS until after the case was closed and a new report (unrelated to the fatality) was registered, on 1/12/2018. The 7065 Agency Reporting Form was submitted on 4/25/2018. The SC was 10 months old at the time of her death.

Executive Summary

The female SC was 8 months old at the time an SCR report was made on 12/19/2016, naming her and her 3 SS as alleged maltreated children against her BM and BF. UCDSS became involved with the family on that date and used the CPS-FAR approach. The SC died on 3/4/2017 while the case was still open, though nearing its conclusion. The SC's death was never reported to the SCR, and the family did not inform UCDSS of the death prior to the FAR case being closed. UCDSS had concluded casework activity with the family only 2 days prior to the SC's death.

UCDSS learned of the fatality during a new FAR case, in which concerns unrelated to the fatality were reported to the SCR on 1/12/2018. The SC had been named as a child on that report even though she had died 8 months prior, unbeknownst to the source and UCDSS. On 1/16/2018, the BM informed the FAR worker SC died of natural causes. Supervisory consultation noted UCDSS had knowledge from CPS history that the SC was a medically fragile child, who was now reported by the BM to have died from medical complications.

The information UCDSS learned about the fatality came from the BM, though SC's medical history was known from prior CPS cases; however, her actual diagnosis and prognosis were never documented as having been received from any medical provider. BM stated SC was born with a rare developmental muscle and joint disorder and died due to complications of pneumonia. BM explained because of this disorder, SC was unable to move certain muscles and was therefore unable to cough, causing a buildup of fluid in her lungs which eventually led to her death. BM noted SC's condition made her particularly vulnerable to the pneumonia and other illnesses, and stated this was explained to BM and BF when SC was born. The 7065 Agency Reporting Form noted the parents were told at the time of her birth that SC would likely not survive for more than 1-2 years, and UCDSS informed OCFS that this information was learned from a conversation with BM.

UCDSS did not ask for any releases to gather outside information about the fatality, though they did ask BM for a copy of the death certificate, which BM reported she did not have. BM appeared distressed addressing the topic of her daughter's death; therefore, UCDSS was unable to gather specific information surrounding detailed information from the circumstances of the death, including but not limited to: where the death occurred, who was present at the time of her death, whether 911 was called, whether LE was involved, and confirmation of the exact etiology of the SC's passing.

Though UCDSS learned the death occurred in the recent past while a case was open with them at that time, the 7065 Agency Reporting Form was not submitted to OCFS within 72 hours of learning of the death, as required. Since OCFS recently issued guidance to clarify requirements when a child death occurs in an open FAR case, there will not be a citation for this issue. Rather, it is recommended that UCDSS review current OCFS guidance on notifications.

In the period of time between the date of the fatality and OCFS notification, there have been additional CPS reports – two

involving the SC's household (BM, BF, and 3 SS), and two involving the eldest SS in the household of his BF. All were conducted using the FAR approach. A FAR case in each of those two households remained open at the time of the writing of this report. OCFS reviewed the closed cases, and some practice issues were found. Those practice issues have been referred to the Spring Valley Regional Office for inclusion in their PIP.

PIP Requirement

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.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:

There was no fatality investigation. Further, regulatory procedure in Family Assessment Response cases is such that there is no determination of allegations, no determination of the report, and no safety assessment due at the time of the closing of 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:

There was documentation of consultation with supervisors at pertinent points throughout UCDSS' involvement. The decision to close the FAR case was appropriate given the circumstances.

Required Actions Related to the Fatality

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

Issue:	FAR-Failure to Offer and/or Provide Needed Services
Summary:	On 2/8/2018, BM identified BF was suffering as a result of the fatality, though UCDSS did not discuss the fatality with him or offer any services he may have needed.
Legal Reference:	18 NYCRR 432.13 (e)(2) (vi) & (vii)

Action:	Service needs should be fully explored and when service needs are identified, UCDSS will make the appropriate referrals to services that could benefit the family.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/04/2017 **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? Unknown
Did EMS respond to the scene? Unknown
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Unable to determine

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	10 Month(s)
Deceased Child's Household	Father	No Role	Male	36 Year(s)
Deceased Child's Household	Mother	No Role	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Other Household 1	Other Adult - Eldest SS's BF	No Role	Male	34 Year(s)

LDSS Response

On 1/12/2018, UCDSS became involved with the SC's family due to an SCR report, and UCDSS initiated the FAR approach. The circumstances met the eligibility criteria to maintain the case as FAR. FAR techniques and strategies were used and well-documented. Upon their first face-to-face contact with the family, UCDSS learned the SC had died 8 months prior to the report date, and therefore determined the SC was inaccurately listed on that report. The BM informed

UCDSS that the SC died on 3/4/2017, and it was discovered the date of death occurred while UCDSS had been involved in a FAR case with the family between the dates of 12/19/2016 and 3/23/2017. UCDSS had completed their final home visit on 3/2/2016, noting no concerns, and closed the case shortly thereafter. The family did not report the SC's death to UCDSS during the final two weeks of the open case, and the SC's death was never reported to the SCR. BM reported SC died due to complications of pneumonia, exacerbated by her previous health condition (a rare muscular disease).

While UCDSS was involved with the family while SC was still alive, the FAR worker made an initial home visit on 12/20/2016 to the SC's household and observed SC's therapist working with her, doing a physical activity. This collateral contact, with whom UCDSS interviewed, was employed by Early Intervention and worked with the SC on occupational therapy, physical therapy, and speech. He had been working with SC since birth. He noted SC's muscle and joint disorder was diagnosed during BM's pregnancy. He stated SC was doing well and would surpass what the doctors expected of her, noting that doctors felt she would not be able to work, but reported that had changed. The worker had no safety concerns for the SC, and shared he had no concerns for the level of care BM and BF provided to the children. UCDSS made a final home visit on 3/2/2017, and observed SC napping in a bouncy chair. There was no observation of the SC being ill, or any other family member for that matter, and no family member indicated such. UCDSS discussed safe sleep with the BM.

During the FAR case that was open at the time of the fatality, UCDSS did not speak with SC's pediatrician or any other medical provider, but it was noted in the Family-Led Assessment Guide that she was up to date on all medical needs (according to the family). The pediatrician was not contacted about the SC during the recent FAR case as well.

During the most recent FAR case, the FAR worker talked face-to-face with the parents on 1/16/2018, at which time BM reported SC had died in March of 2017. On 4/27/2018, BM elaborated that the SC died due to complications of pneumonia, as SC was unable to cough and built up fluid in her lungs which led to her death. Though it was noted in the 7065 reporting form, the case record did not indicate any notation of life expectancy timeframes as a result of SC's medical condition, and it did not appear the death was expected; however, BM noted SC's pediatrician had told them that SC's condition made her more vulnerable to pneumonia and other illnesses. BM would not elaborate further on the circumstances surrounding the death, so many details remained unknown.

UCDSS did not record having spoken with the BF or SS about the SC's death, though the children who were of developmental age were interviewed about the latest SCR report and assessed for safety. UCDSS offered grief services to BM, which she declined, stating she was coping well with her grief. BM noted BF was not coping well, though services were not offered to him.

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: Unknown

Multidisciplinary Investigation/Review

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

CPS Fatality Casework/Investigative Activities

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

Additional information:
While some contacts are only required in a CPS investigation, best practice for fatality-related information-gathering includes efforts to gather as much information as possible regarding the facts and circumstances of the death.

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:
The 24-hour and 30-day safety assessments were not required as the death was never reported to the SCR. There were no safety factors identified throughout the case which placed the children in immediate or impending danger of serious harm.

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: Some services were offered, but other needed services were not - services were offered to BM only.				

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 or needed to be removed.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐

Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
It was noted that services were offered to the BM, which BM declined, but it was unclear whether the offer was extended regarding the SS. One SS was receiving mental health services for reasons apparently unrelated to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services related to the fatality were offered to BM but not to BF. BM declined the offer for services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? Yes

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 fetal alcohol effects or syndrome
☒ With neither of the issues listed noted in case record

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)
12/19/2016	Sibling, Male, 11 Years	Mother, Male, 32 Years	Inadequate Guardianship	Far-Closed	Yes
	Sibling, Male, 11 Years	Mother, Male, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 6 Years	Mother, Male, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 6 Years	Mother, Male, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 3 Years	Mother, Male, 32 Years	Lack of Supervision	Far-Closed	
	Deceased Child, Female, 8 Months	Mother, Male, 32 Years	Lack of Supervision	Far-Closed	
	Sibling, Male, 11 Years	Mother, Male, 32 Years	Lacerations / Bruises / Welts	Far-Closed	
	Sibling, Male, 11 Years	Mother, Male, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 11 Years	Mother, Male, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 6 Years	Mother, Male, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 6 Years	Mother, Male, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 3 Years	Mother, Male, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 3 Years	Mother, Male, 32 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 3 Years	Mother, Male, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Deceased Child, Female, 8 Months	Mother, Male, 32 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Deceased Child, Female, 8 Months	Mother, Male, 32 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Female, 8 Months	Mother, Male, 32 Years	Parents Drug / Alcohol Misuse	Far-Closed	
	Sibling, Male, 11 Years	Father, Male, 37 Years	Parents Drug / Alcohol Misuse	Far-Closed	

Sibling, Male, 6 Years	Father, Male, 37 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Male, 6 Years	Father, Male, 37 Years	Parents Drug / Alcohol Misuse	Far-Closed
Sibling, Male, 3 Years	Father, Male, 37 Years	Parents Drug / Alcohol Misuse	Far-Closed
Deceased Child, Female, 8 Months	Father, Male, 37 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Male, 11 Years	Father, Male, 37 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Male, 11 Years	Father, Male, 37 Years	Inadequate Guardianship	Far-Closed
Sibling, Male, 11 Years	Father, Male, 37 Years	Lack of Supervision	Far-Closed
Sibling, Male, 6 Years	Father, Male, 37 Years	Inadequate Guardianship	Far-Closed
Sibling, Male, 6 Years	Father, Male, 37 Years	Lack of Supervision	Far-Closed
Sibling, Male, 3 Years	Father, Male, 37 Years	Inadequate Food / Clothing / Shelter	Far-Closed
Sibling, Male, 3 Years	Father, Male, 37 Years	Inadequate Guardianship	Far-Closed
Sibling, Male, 3 Years	Father, Male, 37 Years	Lack of Supervision	Far-Closed
Deceased Child, Female, 8 Months	Father, Male, 37 Years	Inadequate Guardianship	Far-Closed
Deceased Child, Female, 8 Months	Father, Male, 37 Years	Lack of Supervision	Far-Closed
Deceased Child, Female, 8 Months	Father, Male, 37 Years	Parents Drug / Alcohol Misuse	Far-Closed

Report Summary:
SCR report alleged BM hit the 11yo SS with her fists and spatulas; as a result, he had sustained bruises on his back, side, and thigh. The SS was also afraid of his stepfather (BF) because he hit him as well. The report further alleged BM and BF abused drugs. While under the influence, they would sleep and not take care of the CHN, at which point the 11yo SS had to care for the younger CHN. At times there was no food in the home and the 11yo SS had to wear BM's clothes because his were dirty. SC had a disability which involved her muscles and she had a feeding tube, and would be left in the care of the 11yo SS because his parents would be sleeping. The role of the 11yo's BF was unknown.

OCFS Review Results:
BM and BF denied using physical discipline on any of the CHN, and the 11yo SS denied this as well. UCDSS did not observe any marks or bruises on the SS and he did not express fear toward any of his caregivers. UCDSS spoke with the SS's therapist who reported having no concerns for the care BM and BF provided the SS. UCDSS noted the parents cared for the CHN well. UCDSS addressed the reported concerns and assessed other areas of potential child welfare concern. UCDSS spoke with necessary collateral contacts to gather information about the reported concerns.

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

Issue:
FAR-Timely/Adequate 7-Day Assessment

Summary:
The 7-day safety assessment was 2 days overdue.
Legal Reference:
18 NYCRR 432.13 (d)(2)(i) and (ii); 18 NYCRR 432.13(d)(3)
Action:
UCDSS will complete all safety assessments in the amount of time required.

Issue:
FAR-Failure to Provide Notice of Report
Summary:
The 11yo SS's BF was the only adult documented as having been provided with a Notice of Existence Letter.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
UCDSS will mail or deliver notification letters to subject(s) and parent(s) within the first seven days following the receipt of the report.

Issue:
Case record contains information that is relevant, useful, factual and objective
Summary:
The record does not reflect updated dates of birth for several persons named in the report. For that reason, there are several discrepancies throughout the case record regarding ages of the children.
Legal Reference:
18 NYCRR 428.1 (b)(1)
Action:
UCDSS will obtain dates of birth for all persons with whom they are involved, and record with accuracy in the case record.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/14/2014	Other Child - SS's BF's Girlfriend's Child, Male, 6 Years	Other Adult - SS's BF, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - SS's BF's Girlfriend's Child, Male, 6 Years	Other Adult - SS's BF's Girlfriend, Mother to Other CHN in Home, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - SS's BF's Girlfriend's Child, Male, 6 Years	Other Adult - SS's BF's Girlfriend, Mother to Other CHN in Home, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Years	Other Adult - SS's BF, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 8 Years	Other Adult - SS's BF's Girlfriend, Mother to Other CHN in Home, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - SS's BF's Girlfriend's Child, Male, 8 Years	Other Adult - SS's BF's Girlfriend, Mother to Other CHN in Home, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	

Other Child - SS's BF's Girlfriend's Child, Male, 8 Years	Other Adult - SS's BF, Male, 31 Years	Inadequate Guardianship	Unsubstantiated
Other Child - SS's BF's Girlfriend's Child, Male, 6 Years	Other Adult - SS's BF, Male, 31 Years	Inadequate Guardianship	Unsubstantiated
Other Child - SS's BF's Girlfriend's Child, Male, 6 Years	Other Adult - SS's BF, Male, 31 Years	Lacerations / Bruises / Welts	Unsubstantiated

Report Summary:
SCR report alleged there was ongoing violence in the eldest SS's home, where he resided with his BF, his BF's girlfriend, and her children. SS was 8yo at the time of the report. His BF was allegedly abusive to a 6yo CH in the home, and SS and the other 8yo CH were abusive to the two 6yo CHN in the home. SS's BF would tie the 6yo's hands behind his back with rope and hit him with hard objects, and left bruises in the past. The older CHN hit the younger CHN with metal swords and handcuffed one of them. In the past, one of the CHN stabbed the other in the head causing him to have stitches. The other CHN's mother did nothing to protect the CHN.

Report Determination: Unfounded | **Date of Determination:** 01/06/2015

Basis for Determination:
UCDSS interviewed all family members and observed the CHN named in the report, finding no injuries. It was clarified the handcuffs were toys, unable to be locked; and, all denied corporal punishment. It was also clarified the CHN's BM intervened when the CHN fought. SS brought a bamboo stick into the home which the CHN were calling a sword, though the other CHN's mother had removed it from the home prior to the report. Though it was confirmed 1 of the 6yo CHN cut the other 6yo CH with a knife during the summer, no concerns for parental maltreatment were discovered. Events as alleged were described by family members as "horseplay" and done without malice or resulting in injuries.

OCFS Review Results:
UCDSS conducted a thorough investigation and spoke with all necessary parties. UCDSS documented that Preventive Services were actively involved with the other CHN and their mother in that home; and, the Preventive worker informed there had been no ongoing safety concerns. In interviewing all family members separately, UCDSS was able to corroborate the information learned therein, and uncovered no safety concerns.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment was 16 days overdue.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
UCDSS will complete all safety assessments in the amount of time required.

Issue:
Failure to provide notice of report
Summary:
The other CHN's mother was the only adult provided with a Notice of Existence Letter.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
UCDSS will mail or deliver notification letters to subject(s) and parent(s) within the first seven days following the receipt of the report.

[redacted]

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

There was no CPS history more than 3 years prior to the fatality; however, there was history between the time of the fatality and OCFS notification, as noted in the Executive Summary.

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