Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-20-036

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

Issue Date: Feb 16, 2021

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: 12 year(s)
Jurisdiction: Ulster
Gender: Female
Date of Death: 08/27/2020
Initial Date OCFS Notified: 08/27/2020

Presenting Information

An SCR report received stated that the subject child had been hospitalized for suicidal ideation and was discharged in June 2020 after receiving inpatient treatment. It was unknown if the child had a mental health diagnosis, but the mother was aware of the situation. The mother was also aware that the subject child was experiencing suicidal ideation the night of 8/26/20. The mother failed to seek appropriate medical treatment for the child. Instead, she gave the child a Tylenol PM. The mother then left the home around 11:00PM to go to the store. The grandmother and two other children were in the home with the subject child. It was unknown if the mother made the grandmother aware that the child was suicidal before she left. After the mother left the home, the mother abused heroin and fell asleep in her vehicle in a parking lot. On 8/27/20, the mother found the child unresponsive some time before 12:00PM. She could not be revived, and ultimately passed away from a suspected overdose.

Executive Summary

On 9/2/20, Ulster County Department of Social Services (UCDSS) received an SCR report regarding the death of the 12-year-old subject child. At the time of her death, the child resided with her mother, 4yo sibling and maternal grandmother. The child's father did not reside in the home, but had regular visitation. The family had an open CPS investigation at the time of the fatality in relation to concerns about the mother's substance use and an allegation of sexual abuse against the step-grandfather in relation to the subject child.

UCDSS completed casework and collateral contacts and learned that a couple months prior to the death, the subject child was admitted to inpatient psychiatric care after an attempted suicide. The child was diagnosed with Major Depressive Disorder and discharged from the facility with a recommendation for outpatient mental health services and a continuation of her prescribed medication. On the night of 8/26/20, the subject child was upset and had expressed thoughts of self-harm to her mother. The mother took the subject child for a drive to a friend's home and they returned several hours later. Security footage from the residence showed that upon returning home, the subject child presented as drowsy, with slurred speech and had difficulty walking and keeping her eyes open. The mother brought the child into the house and then left a couple hours later. The mother stated she left the home to use heroin and had fallen asleep in a parking lot. The mother returned home at 11:21AM and found the child unresponsive in her bedroom sometime before 12:00PM. First responders arrived and the child was unable to be revived and was pronounced deceased.

An autopsy was completed and revealed that the child's preliminary toxicology report was positive for fentanyl, benzodiazepines, caffeine, anti-depressants and cold medicine. The fentanyl was identified to be a lethal level. The mother reported on going substance abuse leading up to the child's death and the mother's drug tests following the death were positive for several substances, including fentanyl and benzodiazepines. The mother reported she had given the child an Advil PM the night prior to the fatality; however, denied providing her with any other substances or that the child had access to any drugs. Law enforcement had an open criminal investigation related to the death at the time the CPS investigation was closed.

UCDSS offered supportive services for the family following the fatal incident. The mother, father, grandmother, sibling's father and sibling were offered grief counseling and funeral arrangements. The father was spoken to via telephone regarding the death and SCR report, but efforts were not documented to interview him face-to-face. The sibling was present at the time the subject child was discovered deceased and was observed in the home video footage when the mother brought the subject child home. Although the most recent Family Assessment Services Plan identified the 4yo

sibling to be above average cognitively, there were no efforts documented to interview her about the fatality or overall safety and risk.

UCDSS developed a safety plan immediately following the fatality that restricted the mother's contact with the sibling to supervised by the maternal grandmother. UCDSS requested the mother be court ordered to engage in services, which was granted. The mother violated the conditions of the petition and UCDSS filed a neglect petition and requested the removal of the sibling. The sibling was removed and continued placement with the maternal grandmother was ordered. The allegations were correctly substantiated against the mother given the information obtained during the investigation. The family was opened to UCDSS' foster care unit and the CPS investigation was indicated and closed on 10/20/20.

PIP Requirement
This review resulted in a citation related to casework practice. In response, UCDSS will submit a PIP to the Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the UCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, UCDSS will review the plan(s) and revise as needed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **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

Was the decision to close the case appropriate? N/A
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The suriving sibling was removed from the mother's care and placed with the grandmother and a foster care case was opened.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	Although the father was contacted and spoken to on the phone regarding the SCR report, the record did not reflect that he was interviewed face-to-face or that there were barriers present which prevented this.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	UCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-day safety assessment tool was completed late in Connections on 10/5/20.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	A safety assessment will be documented and approved by a supervisor within 30 days of a report if such report contains the allegation of DOA/Fatality, as required.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-day Fatality Report was completed late in Connections on 10/5/20.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	UCDSS must document and approve a 30-day Fatality Report within 30 days of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in Connections for all reports containing an allegation of a child fatality.
Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	It was not documented that the surviving sibling was interviewed regarding the SCR report or overall safety and risk.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/27/2020 **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: Unknown
Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? Yes

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? No - but needed

At time of incident supervisor was:

- ☒ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☒ Absent
- ☒ Asleep
- ☐ 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	12 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	69 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	57 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)
Other Household 1	Father	No Role	Male	46 Year(s)
Other Household 2	Other Adult - Father of the 4yo sibling	No Role	Male	57 Year(s)

LDSS Response

On 9/2/20, UCDSS received a report regarding the death of the SC that occurred on 8/27/20. UCDSS immediately initiated their response and within 24 hours of receipt of the SCR report spoke to the source, completed a CPS Hx check, completed a home visit, assessed the SS for safety and conducted multiple interviews. At the time of the fatality the SC resided with the SM, 4yo SS and MGM.

UCDSS attempted to interview the SM; however, she was not cooperative and refused to provide complete details regarding the events leading up to the fatality or answer questions about her substance use. The SM stated that the SC was depressed the days leading up to her death. The SM had seen cuts on the child's arms and planned to address it in the child's therapy session, which was scheduled for the day of her death. The SM stated the child had missed a therapy session the Monday prior to the death. On 8/27/20, the SM discovered the SC unresponsive when she went into the SC's bedroom to administer her MH medication. The SM refused to provide further details and requested the presence of an attorney.

Interviews and information gathered from collaterals revealed that the night prior to the fatality the SM left the home with the SC around 9:22PM and returned around 1:21AM. Video footage from the home showed the SM holding the SC up as she walked her into the home. The SC was drowsy, with slurred speech, closed eyes, and was heard coughing and gagging.

The SM was next seen leaving the home again at 3:21AM and returned at 11:25AM. During the SM's interview with LE, she reported she had taken the SC to a friend's home, and the SC waited in the car alone while the SM went inside. The SM then drove with a friend and the SC to get food, drove the friend home then returned to the case address. The SM reported that when she left the home at 3:21AM, she had used heroin and fell asleep in her car. When asked about drug use by the SC, the SM reported she had given the SC an Advil PM and denied providing the SC with any other substances. The SM denied the SC had access to drugs in the SM's car or the home.

During the investigation, it was discovered that the SC had been in inpatient mental health Tx a few months prior to her death. Upon leaving the facility, it was recommended the SC attend outpatient therapy and take her prescribed medication. Collateral contact was made with the MH serivce provider, who reported that SM typically had the SC attend her sessions and would reschedule as needed. The provider reported the SC had not expressed any suicidal ideations in their sessions. It was further reported that the SC's appointments were via telephone and it did not appear that she had privacy during her sessions.

The BF was interviewed via telephone and reported no knowledge of the SM's drug use. He reported the SC stayed with him for a month after her discharge from the hospital and he ensured she followed her Tx recommendations. The BF reported concerns that the SC was not regularly attending her scheduled MH appointments once she returned to the SM. The MGM was interviewed and reported the SC was crying a lot the days leading up to her death. The night before the death, the MGM was aware the SM had left with the SC, but was not awake when they returned home or when the SM left the home again. The MGM was aware the SM had a historical problem with drug use; however, denied knowledge of any current use.

The SM admitted to substance abuse prior to the fatality and produced positive drug screens during the investigation. The SM was recommended for inpatient addictions counseling Tx, which she attended and then left against medical advice. UCDSS sought a court ordered removal and the 4yo SS was placed with the MGM. An OP was granted, which permitted supervised visitation between the SM and SS. UCDSS completed a visit at the sibling's BF's home and he was informed of court proceedings, but reported he wanted the SS to remain with the MG

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No
Comments: UCDSS contacted law enforcement and requested records and information regarding their criminal investigation.

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 Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

056051 - Deceased Child, Female, 12 Year(s)	056085 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
056051 - Deceased Child, Female, 12 Year(s)	056085 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
056051 - Deceased Child, Female, 12 Year(s)	056085 - Mother, Female, 33 Year(s)	Lack of Medical Care	Substantiated
056084 - Sibling, Female, 4 Year(s)	056085 - Mother, Female, 33 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☐	☒	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

It was not documented that the father of the subject child or the sibling were interviewed face-to-face. Although LE was spoken to, the record did not reflect EMS or the pediatrician was contacted in relation to the fatality.

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:
Within 24 hours of receipt of the SCR report, the suriving sibling was placed with the maternal grandmother as part of a safety plan developed by UCDSS. On 9/30/20, UCDSS requested a removal of the sibling in family court. The sibling was removed from the mother and placed with the grandmother.

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:**
10/02/2020	There was not a fact finding	There was not a disposition
Respondent:	056085 Mother Female 33 Year(s)	
Comments:		

Have any Orders of Protection been issued? Yes	
From: 10/02/2020	**To:** Unknown
Explain: There was an order of protection between the mother and surviving sibling, which required 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	☐	☐	☐	☐	☐	☒	☐

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 4yo sibling was in receipt of grief counseling and referred to mental health counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother, father, grandmother and father of the sibling were offered grief counseling services and assistance with the funeral.

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?	No

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)
07/10/2020	Deceased Child, Female, 12 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 12 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 33 Years	Parents Drug / Alcohol Misuse	Substantiated	
	Deceased Child, Female, 12 Years	Grandparent, Male, 67 Years	Sexual Abuse	Unsubstantiated	

Report Summary:
An SCR report alleged that on at least one occasion, the grandfather touched the subject child in a sexually inappropriate manner. Further details were unknown. The mother used drugs and unknown pills to the point of impairment while caring for the subject child and sibling. The mother used the drugs in the direct presence of the children and left the drugs accessible to them. The mother drove while impaired with the children and had gotten into a car accident on at least one occasion. There were no known injuries to the children.

Report Determination: Indicated | **Date of Determination:** 09/23/2020

Basis for Determination:
UCDSS substantiated the allegations of IG and PD/AM against the mother, as the mother admitted to heroin use. The allegation of sexual abuse was unsubstantiated. The subject child was forensically interviewed and made no disclosures.

OCFS Review Results:
UCDSS assessed for safety of the children within 24 hours of the receipt of the SCR report. UCDSS spoke to the source, completed a CPS history check and interviewed the subject child, grandparents and mother. Assessments were completed with accurate information obtained during the investigation. Not all required face-to-face contacts were completed. It was not documented that notification of indication letters were sent.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
Although the record reflected phone calls with the father, it was not documented that there were efforts made to interview him face-to-face, or conduct a visit at his home.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
UCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

Issue:
Failure to Provide Notice of Indication

Summary:
The record did not reflect that notice of indication letters were sent.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
If UCDSS determines, within 60 days, a report assigned to the investigative track is "indicated" they must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/09/2018	Sibling, Female, 2 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report alleged that on 7/8/18 the mother brought the surviving sibling to a house with known drug activity. While there, an unknown individual overdosed in the presence of the sibling. The sibling did not sustain any injuries as a result of the incident.

Report Determination: Unfounded **Date of Determination:** 12/15/2018

Basis for Determination:
UCDSS unfounded the allegation against the mother after interviews with casework and collateral contacts. The mother, subject child and family members denied the concerns of the report and LE who responded to the location of the alleged overdose reported no concern for drug use.

OCFS Review Results:
UCDSS assessed for safety of the children within 24 hours of the receipt of the SCR report. UCDSS spoke to the source and interviewed the subject child, grandparents and mother. The fathers of the children were identified, added to the

investigation and notified of the SCR report in writing; however, there were no efforts documented to interview them face-to-face. The 7-day safety assessment and CPS history check were not completed within required time frames. A collateral contact revealed the mother had admitted to drug use the night the SCR report was made; however, this was not addressed with her. The unknown person was identified and there were no efforts documented to interview her.

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

Issue:
Review of CPS History
Summary:
The CPS history check was documented late in Connections on 10/6/18.
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, UCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day safety assessment tool was completed 3 months after the receipt of the SCR report.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
UCDSS will document and approve all safety assessments within the required time frame.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The unknown individual referenced in the SCR report was identified during the investigation; however, it was not documented that there were efforts made to interview her.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
UCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition
Summary:
UCDSS obtained information that the mother admitted to LE that she had used drugs the night the SCR report was made; however, the record did not reflect that this was discussed with the mother.
Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)
Action:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. UCDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
UCDSS documented a phone call with the father; however, the record did not reflect efforts were made to interview him face-to-face. The sibling's father was added and notified of the SCR report but it was not documented that efforts were made to interview him.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
UCDSS will make efforts to make face-to-face contact with a child and/or a child's parents or guardians and document efforts that were unsuccessful.

[redacted]

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

In 2016, there was one unfounded CPS investigation with allegations of inadequate guardianship against the mother in regards to the surviving sibling.

Known CPS History Outside of NYS

There was 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? There was no legal activity

Additional Local District Comments

Issue - The child was not interviewed regarding the death of her sister or overall safety and risk assessed

The father was not seen face to face

Reason: The mother and the grandmother did not want the child to be interviewed because they did not the child did see her sister deceased and did not want the child to be further traumatized. The child was seen by a caseworker on 8/28/2020 and 9/1/20 during both home visits child was assessed for safety and risk.
The father was not seen face to face because the father did not reside in Ulster County, was not the alleged subject of the report, he has no other children, and was very angry and uncooperative during the phone conversation on 8/31/20.

Issue (Page 9) – EMS or the pediatrician were not contacted.

Reason: When the fatality occurred, there was an open investigation where it is documented that on 7/30/20 the health questionnaire was received and documented in the case notes. EMS was not contacted because when the Agency received the information regarding the fatality the police were already involved and had been in the home when the child was declared deceased by M.E.

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