Child Fatality Report

Report Identification Number: SV-20-042

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

Issue Date: Apr 08, 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	

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Ulster
Gender: Male
Date of Death: 10/26/2020
Initial Date OCFS Notified: 10/26/2020

Presenting Information

An SCR report alleged on 10/23/2020, the 3-month-old male subject child was in bed crying. The father stepped out of the room for an unknown length of time. When the father heard the child stopped crying, he went back into the room, where he found the child unresponsive. He attempted to perform CPR and called EMS. The child was transported to the hospital where he was diagnosed with a non-accidental trauma that included brain swelling, an anoxic brain injury, retinal detachment and bi-lateral retinal hemorrhaging. The father was unable to provide an explanation for the child's injuries. The child was declared brain dead on 10/26/2020 at 4:40 PM as a result of his injuries. The roles of the mother and the 1-year-old sibling were unknown. The report was subsequent to an SCR report made on 10/23/2020 regarding the child's unexplained injuries.

Executive Summary

This fatality report concerns the death of the 3-month-old male subject child that occurred on 10/26/2020. A report was made to the SCR on 10/23/2020 alleging the child had unexplained injuries while in the care of the father. A subsequent report was made on 10/26/2020 regarding the child's death. The child resided with his parents and 1-year-old sibling. On 10/24/2020, the parents gave consent for the sibling to be placed in the care of the maternal grandparents. The grandparents were emergency certified as foster care parents. On 10/28/2020, Article 10 Petitions were filed against the parents with regard to the sibling. In Family Court on 10/29/2020, the sibling was formally removed from the father's custody and returned to the mother. The sibling was assessed to be safe throughout the duration of the investigation.

Ulster County Department of Social Services (UCDSS) coordinated investigative efforts with law enforcement immediately upon receipt of the initial report. The investigation revealed the father shook the child which caused non-accidental trauma to the child's brain and resulted in the child's death. On 10/28/2020, the father was arrested for murder in the second degree as he confessed to shaking the child. At the time this report was written, the father was out on bail. An autopsy was performed, and the cause of death was anoxic encephalopathy due to shaken/blunt force trauma. The manner of death was homicide.

The father initially said the child was inconsolable when he placed the child down for a nap and left the room. When the father returned, the child was unresponsive and not breathing. The father called 911 and the child was transported to the hospital where he was on life-support until he was declared deceased. On 10/28/2020, the father was interviewed at the police precinct and disclosed that he became frustrated with the crying child and shook the child which caused the child to seize up and go unconscious.

The mother was not home at the time of the fatal incident and had no information to add. The Petition that was filed against her was withdrawn as she had no role in the child's death. The sibling was returned to her care on 10/29/2020 and an Order of Protection was granted against the father with regard to the sibling. The sibling was assessed to be safe with the mother.

UCDSS gathered additional information regarding the death from extended family, first responders and the hospital. The information gathered was used to substantiate the allegations of DOA/Fatality, Internal Injuries, Inadequate Guardianship and Swelling/Dislocation/Sprains against the father regarding the child. Although UCDSS filed Article 10 Petitions against the parents regarding the sibling, allegations were not added on behalf of the sibling. The Risk Assessment Profile was completed inaccurately as it did not reflect the sibling was in the care of an alternate caregiver. UCDSS completed the

required reports and Safety Assessments timely; however, the Safety Assessments were completed with respect to the child and although they reflected factual information, they were not completed with regard to the sibling. UCDSS offered the mother bereavement services, trauma counseling and burial assistance. UCDSS opened a Preventive Services Case to provide ongoing monitoring and support to the family.

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
Casework activity was commensurate with case circumstances.

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

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

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

Explain:
UCDSS opened a Preventive Services Case to provide ongoing monitoring and support to the family.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)

Summary:	The Risk Assessment Profile reflected there were no children in the care or custody of any substitute caregivers at any time prior to the report date; however, the sibling was placed with the maternal grandparents on 10/24/2020.
Legal Reference:	18 NYCRR 432.2(d)
Action:	UCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	Although the Safety Decision was appropriate, the safety factors chosen were in relation to the subject child and not the surviving sibling. The safety factor reflecting the father being violent and out of control was not selected.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be documented in the case record in the form and manner required by OCFS and must be all inclusive of information within the case record. The Safety Assessments are to be completed exclusively regarding surviving children.
Issue:	Appropriate Application of Legal Standards (Abuse/Maltreatment)
Summary:	Although UCDSS filed petitions against both parents regarding the sibling, UCDSS did not add allegations in the CPS investigation against either parent with regard to the sibling.
Legal Reference:	SSL 412(1) and 412(2)
Action:	UCDSS will appropriately apply the definitions of abuse or maltreatment while conducting an investigation. UCDSS will make an SCR report or add allegations regarding maltreatment revealed during an investigation. UCDSS will contact the Westchester Regional Office for guidance if needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/26/2020 **Time of Death:** 04:40 PM

Date of fatal incident, if different than date of death: 10/23/2020
Time of fatal incident, if different than time of death: 05:15 PM

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? N/A
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
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 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	No Role	Female	23 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)

LDSS Response

On 10/23/2020, UCDSS received a report from the SCR regarding life-threatening injuries to the SC while he was in the care of the SF. UCDSS initiated the investigation by coordinating investigative efforts with LE. Prior to the SC's death, the MGF was interviewed. The grandparents cared for the SS while the injuries were investigated. The MGF received text messages stating something was wrong with the SC and that the SF called 911. The grandparents went to the home and the MGF cared for the SS while the parents and the grandmother went to the hospital. A safety plan was created and implemented that the grandparents would care for the SS and he was assessed to be safe.

On 10/24/2020, the parents were interviewed alongside LE. The SF said the SC appeared uncomfortable on the day of the fatal incident and he was brought to the pediatrician's office. The pediatrician changed the SC's formula and the SC was sent home. Around 3:00 PM on 10/23/2020, while the BM was at work, the SF fed the SC. The SF laid the SC down as he was fussy, and the SF left the room to play with the SS. Later, the SF checked on the SC and discovered the SC was not breathing. He shook the SC in an attempt to wake him to no avail. The SF began chest compressions and contacted 911. EMS arrived and took over resuscitation efforts as the SC was transported to the hospital. The BM said the SC cried incessantly before she went to work. She received a call from the 911 dispatcher telling her to go to the hospital. She had no information regarding the SC's condition. The parents signed consent for the SS' removal and he was placed with the grandparents.
UCDSS followed up with the pediatrician who noted the SC was seen on the day of the fatal incident and appeared healthy and there were no reported concerns.

On 10/26/2020, UCDSS received a report from the SCR regarding the death. Medical staff noted the death was a result of non-accidental trauma. Within the first 24 hours of the investigation, UCDSS contacted the source and documented a CPS history check. LE and the DA were notified of the death.

On 10/26/2020, UCDSS assessed the SS to be safe with the grandparents. UCDSS reiterated to the grandparents that the parents were not have contact with the SS. On 10/28/2020, Article 10 Petitions were filed against the parents regarding the SS.

UCDSS gathered information from EMS who stated the SC showed no signs of life and was transported to the hospital as CPR was performed. Hospital staff noted the SC's injuries were consistent with Shaken Baby Syndrome. The autopsy diagnosis also was associated with a shaken baby.

On 10/28/2020, the parents were re-interviewed at the police precinct. The SF said he cared for the children while the mother worked. The child would not stop crying and the father "snapped." The father admitted to shaking the child 3-4 times causing the child to seize up and lose consciousness. The SF called 911 and attempted to revive the child. He was arrested for murder in the second degree.

The BM was interviewed and said she had no knowledge the SF harmed the SC. She reported around 4:30 PM, she had contact with the SF and had no inclination the SF was struggling. Around 5:50 PM, a 911 operator contacted her to notify her of the SC's condition.

On 10/29/2020, the Petitions were heard in Family Court. An OP was issued against the SF regarding the SS. The SS was discharged from foster care and was returned to the mother as the investigation revealed the BM had no role in the SC's injuries or death and the petition against her was withdrawn.

UCDSS completed a thorough investigation and completed all casework activity prior to determining the investigation. The BM was offered services in response to the death including burial assistance and a trauma therapist. The BM accepted the services. UCDSS opened a Preventive Services Case to provide ongoing monitoring of the family while the SF's charges pended.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external 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?No
Comments: Ulster County does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056449 - Deceased Child, Male, 3 Mons	056452 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
056449 - Deceased Child, Male, 3 Mons	056452 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
056449 - Deceased Child, Male, 3 Mons	056452 - Father, Male, 25 Year(s)	Internal Injuries	Substantiated
056449 - Deceased Child, Male, 3 Mons	056452 - Father, Male, 25 Year(s)	Swelling / Dislocations / Sprains	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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

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

Explain:
The Risk Assessment Profile did not reflect the sibling was in the care of an alternate caregiver; however, the sibling was in the care of the grandparents prior to the SCR report regarding the child's death. The mother was accepting of the services offered in response to the death.

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:
Although the safety decision was appropriate, the selected safety factors recorded focused on the subject child without inclusion of the impact on the sibling. The parents consented to the removal of the sibling prior to the Petitions being filed. The sibling was formally removed from the care of the father in Family Court on 10/29/2020.

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:**
10/28/2020	There was not a fact finding	There was not a disposition
Respondent:	056452 Father Male 25 Year(s)	
Comments:	A Neglect Petition was filed against the father with regard to the sibling. At the time this report was written, the disposition was pending.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**

10/28/2020	There was not a fact finding	Widthdrawn
Respondent:	056451 Mother Female 23 Year(s)	
Comments:	The petition against the mother was withdrawn as the father was arrested for the death, and the mother did not have knowledge of how the injuries to the child were caused. UCDSS withdrew their petition and the child was returned to her care.	

Criminal Charge: Murder **Degree:** 2

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
10/28/2020	Father	Unknown	Unknown
Comments:	The father was charged with second degree murder and the criminal case was pending at the time this report was written.		

Have any Orders of Protection been issued? Yes

From: 10/29/2020	**To:** Unknown

Explain:
A No-Contact Order of Protection was filed against the father on behalf of the sibling. At the time this report was written, UCDSS and LE were monitoring that the parents were in compliance with the order.

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 sibling was involved in a Preventive Services Case as a result of the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
UCDSS opened a Preventive Services Case after filing an Article 10 Petition against the father in Family Court. The mother was offered trauma counseling, burial assistance and services through the Child Advocacy Center.

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? Yes
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 neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/23/2020	Deceased Child, Male, 3 Months	Father, Male, 25 Years	Inadequate Guardianship	Substantiated	Yes

Deceased Child, Male, 3 Months	Father, Male, 25 Years	Internal Injuries	Substantiated
Deceased Child, Male, 3 Months	Father, Male, 25 Years	Lack of Supervision	Substantiated

Report Summary:
An SCR report alleged on 10/23/2020, the child was sick and vomited. Later in the day, the father was not providing adequate supervision and found the child unresponsive and without a pulse. The child was blue in color. The child suffered from cardiac arrest. The child was an otherwise healthy child and there was no explanation for the child's cardiac arrest, which was suspicious in nature. The mother was at work when the incident occurred. The mother and 1-year-old sibling had unknown roles.

Report Determination: Indicated **Date of Determination:** 12/21/2020

Basis for Determination:
The allegations of Internal Injuries, Lack of Supervision and Inadequate Guardianship were substantiated against the father. The investigation revealed the father became frustrated with the child and shook him until he became unresponsive. The child suffered brain damage as a result of the shaking. The father was arrested and charged with murder in the second degree.

OCFS Review Results:
The investigation was initiated timely and the source of the report was contacted. A CPS history check was documented timely. Home visits were made and interviews with the family and collateral contacts were thorough. UCDSS created and implemented a safety plan for the sibling. Letters of Notice were provided timely; however, Letters of Indication were not provided to the parents. The basis for determination of the Lack of Supervision allegation was not addressed in the Investigation Conclusion Narrative.

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

Issue:
Failure to Provide Notice of Indication

Summary:
Letters of Indication were provided untimely on 3/15/2021.

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

Action:
Within seven days of the determination, in such form as required by OCFS, when reports are indicated, UCDSS must deliver or mail the subject(s) and other adults named in the report with a written notice of indication letter.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

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