

Report Identification Number: BU-18-008

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

Issue Date: Jul 18, 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: 2 month(s)

Jurisdiction: Erie
Gender: Female

Date of Death: 06/06/2017
Initial Date OCFS Notified: 01/23/2018

Presenting Information

On 1/23/2018, the SCR received a new report on a previously reported fatality about the death of the 2-month-old SC. The new report alleged the SC had nine different rib fractures that were from four separate incidents based on the different stages of healing. Some of the rib fractures were from non-accidental trauma. The parents were named as subjects in this report due to the fractures. It was unknown who inflicted these injuries to the SC. The 1yo SS had an unknown role. On 6/6/17, the SC was on visitation with the SF. The SC was crying and the SF removed the SC from the portable crib and placed the SC in bed with him. At about 5:00AM or 6:00AM, the SC woke up crying and the SF fed her a bottle. The SF then swaddled the SC in a blanket, gave her a pacifier and placed her face down on the bed next to him to sleep. The SF woke at 8:40AM and found the SC unresponsive. The SF called 911 and the SC was transported by EMS to the hospital, where she was pronounced dead.

Executive Summary

This fatality report concerns the death of a 2-month-old (SC) that occurred on 6/6/17. A previous fatality report was issued by OCFS, on 11/30/17 regarding SC's death. On 1/23/18, the fatality was reported again to the SCR with the added allegations of FX against both parents for the SC, and IG against the SM for the SC. Erie County Department of Social Services conducted a joint investigation with LE.

The prior CPS investigation of the fatality was Sub for the allegations of DOA/fatality and IG against the SF regarding the SC. The autopsy results had been pending at the time of the prior determination. At that time, the preliminary report had shown 3 posterior fractures; however, ECDSS had no definitive proof the fractures were inflicted. ECDSS indicated the case and opened a mandated CPS-Services case.

After an anthropological analysis, the final autopsy results identified a total of 9 definitive ante mortem fractures in various stages of healing on the anterior, lateral and posterior rib cage. The ME noted there had been a minimum of 4 separate incidents of injury. The ages of injuries ranged from acute to likely more than 30 days. The ME mentioned that while no acute fatal trauma was seen, the presence of multiple fractures of varying ages and mechanisms was highly suggestive of inflicted trauma.

Within 24 hours of the new report, ECDSS addressed the safety of the 1yo SS who was listed in the household in the 6/6/17 investigation. Based on the final autopsy results, ECDSS filed an amended abuse/neglect petition on 1/23/18. The Family Court Judge ordered the SS to be placed in 1017 custody with the PA. The parents were to have supervised visits only, at separate times.

ECDSS thoroughly addressed the new report, by conducting interviews with the family and all collaterals. The information remained unchanged, except for what was learned in the final autopsy report. Despite the new information, there was still no admission of anyone inflicting injury to the SC. SF's account of the fatality was the same, in that he had placed the SC to sleep next to him in an adult bed, swaddled, on her stomach. SF stated SC's head was turned to the side. This occurred approximately between 5 and 6AM following a feeding. SF went to sleep next to the SC and awoke around 8:40AM. When the SF went to get the SC up to feed her, she was unresponsive. The SF tried to do CPR for a minute then called 911. He continued to perform CPR until EMS and LE arrived. The SC was transported via ambulance to the hospital and was pronounced deceased by the ER physician at 9:45 AM.



ECDSS had notified LE of the new information in the final autopsy report. LE reopened their investigation along with ECDSS. The LE investigation was still pending and no arrests had been made at the time of the writing of this report.

ECDSS made the same determination about the DOA/fatality and IG allegations against the SF, as that information was unchanged. The basis was the SF failed to exercise a minimum degree of care by bed-sharing with the SC, and there were aggravating factors present, which resulted in her death. Based on the final autopsy and the new information about the fractures, ECDSS Sub the allegations of FX and IG against the SM and the SF for the SC. Both parents were held accountable for the injuries that were medically proven to have been sustained at various different times, during which both parents had been sole care givers of the SC. The investigation was IND and remained open for mandated CPS-Services. The SS remained in 1017 custody with the PA and the Family Court hearings were still pending at the time of the writing of this report.

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:

ECDSS gathered sufficient information to make a determination in this case.

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:

The case remained open for services and the SS was placed with a the PA under a 1017 relative placement.

Required Actions Related to the Fatality

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



Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/06/2017

Time of Death: 09:45 AM

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

Unknown

County where fatality incident occurred:

Erie

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

Is the caretaker listed in the Household Composition? Yes - Caregiver 2

At time of incident supervisor was:

Drug Impaired

Absent

Alcohol Impaired

Asleep

Distracted

Impaired by illness

Impaired by disability

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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	20 Year(s)

LDSS Response

ECDSS received an SCR report on 1/23/18, concerning a previously reported fatality that occurred in Erie County on 6/6/17. The death was initially reported to the SCR on 6/6/2017, and was investigated by ECDSS and LE. A Child Fatality Report was issued by NYS Office of Children and Family Services on 11/22/2017.



Within 24 hours of the new SCR report, ECDSS filed an amended Article 10 abuse/neglect petition in Family Court requesting remand of the SS. The amended petition was based on new information in the final autopsy report. The final autopsy findings were completed after an anthropological analysis. While no acute fatal trauma was seen, the presence of multiple fractures of varying ages and mechanisms was highly suggestive of inflicted trauma. The final cause of the death was undetermined. The Family Court Judge ordered that the 1yo SS be placed in 1017 custody with the PA. The SS had been placed with the PA during the previously reported fatality investigation through an Article 10 abuse/neglect petition from 6/6/17 to 6/15/17, at which point she was returned to the SM with mandated CPS-Services.

ECDSS conducted a joint investigation with LE. The SF and the SM were interviewed during this investigation and there was no new information learned about how the SC sustained the rib fractures, nor did they provide any different information about the events leading up to the fatality. The parents denied harming the SC. ECDSS interviewed all previously interviewed collateral contacts and no one had information about how the SC had sustained the rib fractures.

In both the previous investigation and the new investigation, the circumstances about the SC's death remained the same. SF stated that he was covered with a blanket, the SC was swaddled in a separate blanket, and there were no sheets on the bed. He could not recall which direction the SC's head was facing when he placed her on her stomach, or when he picked her up. SF said when he picked her up her mouth was open, which was not out of the ordinary. He called 911, then called the BM and PGF. The PGF took him to the hospital after LE questioned him and took pictures. SF denied any drug use.

The SM reported that the SC was fine when SF picked her up at 6:30/7:00 PM on 6/5/17. When the SM awoke on 6/6/17, she spoke to the SF at 9:00 AM via text. He said he was going to drop the SC off around 9:30/10:00 AM. About 15-20 minutes later, SF called and said that the SC was not breathing and he was taking her to the hospital. The SM said her CP drove her to the hospital, where she was told that the SC had passed away.

ECDSS continued to support and offer all services to meet the needs of all family members. The SS remained in 1017 custody with the PA. The case remained open with mandated CPS-Services and the SM and the SF had supervised visitation with the SS at separate times. The Family Court hearings were ongoing at the time of the writing of this report.

Official Manner and Cause of Death

Official Manner: Accident

Primary Cause of Death: Undetermined if injury or medical cause

Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No

Comments: ECDSS does not have an OCFS approved CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046821 - Deceased Child, Female, 2 Mons	046823 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated



Child Fatality Report

046821 - Deceased Child, Female, 2 Mons	046822 - Father, Male, 20 Year(s)	Fractures	Substantiated
046821 - Deceased Child, Female, 2 Mons	046823 - Mother, Female, 19 Year(s)	Fractures	Substantiated
046821 - Deceased Child, Female, 2 Mons	046822 - Father, Male, 20 Year(s)	DOA / Fatality	Substantiated
046821 - Deceased Child, Female, 2 Mons	046822 - Father, Male, 20 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

The SS was not interviewed due to her age/level of development.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain:
ECDSS offered and provided all services needed to meet the needs of all family members.

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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, court ordered?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain as necessary:
On 1/23/2018 a report was received by the SCR with new information about the death of the SC. The final autopsy report had been completed and as a result of those findings, ECDSS filed an amended Article 10 abuse/neglect petition against both parents. The Judge ordered the SS to be placed under 1017 custody with a relative. The SS was in non-LDSS custody. The case remained open for mandated CPS-Services. The goal was to return the SS to the parents, and CPS services were court-ordered.

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:
01/23/2018	There was not a fact finding	There was not a disposition
Respondent:	046822 Father Male 20 Year(s)	
Comments:	On 1/23/2018, ECDSS filed an amended petition in Family Court and both parents were named as respondents. The amended petition was filed requesting a remand for the SS. This was based new information about the fractures sustained by the SC prior to her death. The final autopsy results noted non-accidental trauma that were in different stages of healing, some were from direct blows, and others were compression fractures. It was unknown who inflicted these injuries on the SC. The Family Court Judge ordered the placement of the SS in 1017 custody with the PA. The case was still pending in Family Court.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	Fact Finding Description:	Disposition Description:
01/23/2018	There was not a fact finding	There was not a disposition
Respondent:	046823 Mother Female 19 Year(s)	
Comments:	On 1/23/2018, ECDSS filed an amended petition in Family Court and both parents were named as respondents. The amended petition was filed requesting a remand for the SS. This was based new information about the fractures sustained by the SC prior to her death. The final autopsy results noted non-accidental trauma that were in different stages of healing, some were from direct blows, and others were compression fractures. It was unknown who inflicted these injuries on the SC. The Family Court Judge ordered the placement of the SS in 1017 custody with the PA. The case was still pending in Family Court.	

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Parenting Skills	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Domestic Violence Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Early Intervention	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Intensive case management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Family or others as safety resources	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:
 The SS was in a 1017 custody and placed with the PA. This was a relative placement and the SS was in non-LDSS Custody. The SS was placed on 1/23/1018.

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:
 On 6/7/17 a safety plan was implemented that the SS stay with the PA following the preliminary results of the autopsy. On 6/15/17, the SS was returned to the SM with preventive services and mandated CPS-Services. A full skeletal x-ray exam was done on the SS, and results were negative for any injury.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:
 ECDSS provided grief counseling services, MH counseling, parent skills training, DV services, Early Intervention services and day care. ECDSS offered resources to assist with funeral costs, but this service was not utilized.

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? No

Infants Under One Year Old

During pregnancy, mother:

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



Infant was born:

- Drug exposed With 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)	Allegation Outcome	Compliance Issue(s)
06/06/2017	Deceased Child, Female, 2 Months	Father, Male, 20 Years	DOA / Fatality	Substantiated	No
	Deceased Child, Female, 2 Months	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	

Report Summary:

On 6/6/17, the 3-month-old SC was discovered not breathing. The SC was visiting the SF. EMS were contacted and the SC was transported to the hospital. While at the hospital, the SC was pronounced dead. The SC had no preexisting medical conditions and was an otherwise healthy child. The SC's death was considered suspicious. The role of the SM and the 1yo SS were unknown.

Report Determination: Indicated

Date of Determination: 08/02/2017

Basis for Determination:

ECDSS found credible evidence to Sub the allegations against the SF. The SF failed to exercise a minimum degree of care by bed-sharing with the SC with aggravating factors present, which resulted in her death. An autopsy was performed and the manner and cause of death were still pending. During the examination, the ME found 3 posterior rib fractures on the left side, that were a few weeks old and had healing calluses. The SC had been cared for by multiple different caretakers during the time period that she would have sustained the injury. The investigation was closed, and a case was opened for mandated CPS-Services.

OCFS Review Results:

ECDSS adequately assessed safety and risk, reviewed CPS history, provided the notice of existence letter within the required timeframe; and, there was evidence of supervisory consultation. The SF and SM were interviewed and necessary collateral contacts were made. ECDSS initiated a safety plan and sought Family Court intervention to protect the SS. ECDSS completed a thorough investigation and appropriately Sub the allegations.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/06/2017	Deceased Child, Female, 27 Days	Mother, Female, 18 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 11 Months	Mother, Female, 18 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 27 Days	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 11 Months	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	

Report Summary:

SCR report alleged the SM and SF often engaged in physical altercations in the presence of the SS, 11 months old, and

SC, 3 weeks old. The situation had been occurring since the previous summer. The altercations occurred in the SF's home while the BM and CHN were visiting. It was unknown if the CHN had been harmed.

Report Determination: Indicated

Date of Determination: 08/14/2017

Basis for Determination:

ECDSS Sub the allegation of IG against the SM and SF regarding the SS and SC. On 4/6/17 the SM and SF engaged in an altercation at the SF's home with the CHN present and LE were called to the home. ECDSS filed an amended Neglect Petition against the SM and SF in Family Court. The parents continued to not be allowed together in the presence of the CHN and the CHN continued to be exchanged for the SF's visitation at the SM's independent living residence. The CPS services case remained open.

OCFS Review Results:

ECDSS adequately assessed safety and risk, reviewed CPS history, provided the notice of existence letter within the required timeframe; and, there was evidence of supervisory consultation. The SF and SM were interviewed and necessary collateral contacts were made. Safe sleep was discussed and documented. ECDSS completed a thorough investigation and appropriately Sub the allegations. During this investigation, the SC was found unresponsive in the SF's bed during an overnight visit, and subsequently passed away. ECDSS initiated a safety plan and sought Family Court intervention to protect the SS. The fatality allegations were investigated separately.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/31/2017	Deceased Child, Female, 3 Days	Mother, Female, 18 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 9 Months	Mother, Female, 18 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 3 Days	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 9 Months	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	

Report Summary:

SCR report alleged on 1/30/17, the SM got into a verbal disagreement with the SF. During the dispute, the SM physically assaulted the SF by punching him in the face and putting a hole in the wall in the presence of the SS, 9 months old. The SS was not injured. A subsequent report was received on 3/3/17 that alleged on that date, the SM and SF engaged in a heated verbal argument in the presence of the SS. The SF left with the SS in a vehicle, with the vehicle door open and the SS not secured in the car seat appropriately. Additional information was received on 3/13/17 that SM and SF engaged in a verbal argument upon BM's return home from the hospital after giving birth to the SC, 3 days old.

Report Determination: Indicated

Date of Determination: 04/19/2017

Basis for Determination:

ECDSS Sub the allegation of IG against the SM and SF regarding the SC and SS. The SM and SF engaged in several significant incidents of DV in close proximity to the CHN. In 1 incident the SM tried to take the SS out of her car seat and the SF moved his car while the door was open to prevent SM from taking her of the car, placing the SS at risk of harm. ECDSS filed an Article 10 Neglect Petition against both parents regarding both CHN in Family Court and a temporary order of supervision was granted. On 4/7/17, it was ordered that the parents were not allowed around each other in the presence of the CHN. The CHN were ordered to be exchanged for visitation at the independent living residence.

OCFS Review Results:

ECDSS adequately assessed safety and risk, reviewed CPS history, provided the notice of existence letter within the



required timeframes; and, there was evidence of supervisory consultation. The SF and SM were interviewed and necessary collateral contacts were made. Safe sleep was discussed and documented. ECDSS completed a thorough investigation and appropriately Sub the allegations. Although SF agreed to Preventive Services, a legal consult took place after the SM refused Preventive Services and there were escalating incidents of DV. ECDSS appropriately filed an Article 10 Neglect Petition to obtain court ordered services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/13/2016	Sibling, Female, 1 Months	Father, Male, 20 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:

SCR report alleged on 5/13/16, the SM and SF engaged in a verbal altercation with each other. The altercation escalated when the SF started hitting the SM while in the presence of the 1-month-old SS. The SS was in close proximity to the altercation. The SM had an unknown role.

Report Determination: Unfounded **Date of Determination:** 07/20/2016

Basis for Determination:

ECDSS Unsub the allegation of IG against the SF regarding the SS. The SM and SF reported that they had an argument while the SS was sleeping in her crib upstairs but denied that a physical altercation took place. There was no evidence gathered to support that the incident occurred. The SM and SS were observed to have no marks and the SM's home appeared to be neat and clean. Collaterals who were contacted had no concerns for the SS. The SM was in Foster Care and residing in a supervised independent living program and was receiving parent training and counseling services.

OCFS Review Results:

ECDSS adequately assessed safety and risk, reviewed CPS history, provided the notice of existence letter within the required timeframes; and, there was evidence of supervisory consultation. The SF and SM were interviewed and appropriate collaterals were contacted. Safe sleep was discussed and documented. ECDSS completed a thorough investigation and appropriately Unsub the allegation due to a lack of credible evidence. The case was closed as no additional service needs were identified.

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

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

There is no history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

There is no known history outside of New York State.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes

Date the preventive services case was opened: 03/23/2017

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes

Date the Child Protective Services case was opened: 03/23/2017

Evaluative Review of Services that were Open at the Time of the Fatality



Child Fatality Report

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If not, how many days was it overdue? The Reassessment FASP was 57 days late.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the FASP consistent with the case circumstances?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional information, if necessary: Family Help Center provided Intensive Home Based Family Preservation Services and Preventive Services to the family.				

Preventive Services History

A CPS Services case opened on 3/23/17, following several incidents of DV between SM and SF in the presence of the SC and SS, that resulted in an IND SCR report. The SM was in Foster Care and residing in an independent living residence. An Article 10 Neglect Petition was filed against SM and SF on 3/15/17 and there was a temporary order of supervision granted on 3/21/17. The SM and SF were referred to MH counseling, parenting skills classes and DV services, as well as intensive home based family preservation services (IHBS). Amended Article 10 Neglect Petitions were filed in Family Court against both parents after another incident of DV on 4/6/17. It was ordered that SM and SF stay away from each other except for the exchange of the CHN for SF's visitation, which was to take place at SM's independent living facility. On 4/28/17, the family transitioned to traditional preventive services. On 10/10/17 there was a dispositional hearing in Family Court and the SM was ordered continue in MH counseling, DV services and parenting skills classes. SF's Neglect Petition was still pending. On 1/23/18, based on new information from the final autopsy report, ECDSS filed an amended



petition and the SS was placed in the care of the PA under a 1017 custody. The preventive services case closed and IHBS re-opened.

Legal History Within Three Years Prior to the Fatality

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

Family Court

Criminal Court

Order of Protection

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
03/15/2017	There was not a fact finding	There was not a disposition
Respondent:	046822 Father Male 20 Year(s)	
Comments:	An Article 10 Neglect Petition was filed in Family Court against SF. The petition was still pending and there had been no fact finding or disposition. On 1/23/18 an amended abuse/neglect had been filed by ECDSS.	

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
03/15/2017	Adjudicated Neglected	Order of Supervision
Respondent:	046823 Mother Female 19 Year(s)	
Comments:	An Article 10 Neglect Petition was filed in Family Court against SM. On 8/30/17 there was a finding of Neglect and on 10/10/17 SM was issued court ordered services for 1 year with an adjournment in contemplation of dismissal. On 1/23/18 an amended abuse/neglect had been filed by ECDSS.	

Additional Local District Comments

We at the Erie County Department of Social Services appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality or to the CPS investigations conducted during the three years preceding the fatality.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? Yes No

Are there any recommended prevention activities resulting from the review? Yes No