Child Fatality Report

Report Identification Number: BU-18-024

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

Issue Date: Jan 11, 2019

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 2 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 07/27/2018
Initial Date OCFS Notified: 07/30/2018

Presenting Information

An SCR report alleged, on 7/27/18, the two-month-old child was sleeping in his bassinet while in the care of the mother. The mother checked on child after two hours and after another two hours checked on him a second time. The child was unresponsive on the second check. At approximately 3:30PM a 911 call was made. The fire department responded and attempted to revive the child, but he had already passed away. Rigor mortis had set in four hours earlier, which made the death suspicious. The home was in deplorable condition and presented a safety hazard for subject child and two-year-old surviving sibling. The home had diapers, garbage, toys, and clothing scattered throughout and was infested with fleas, flies, and bed bugs.

Executive Summary

On 7/27/18, Erie County Department of Social Services (ECDSS) received a report from the SCR about the death of a two-month-old child that occurred on the same date. At the time of the fatality, there was a two-year-old surviving sibling in the home, and it was determined that the deplorable conditions posed safety concerns to the child. ECDSS implemented a safety plan for the SS to stay with relatives.

Through interviews with the SM, it was learned on 7/27/18 at approximately 3:45 PM, SM attempted to wake the SC up from a nap and found SC unresponsive in his bassinet. SM called 911 immediately and LE responded to the home and determined SC was dead on arrival. Upon EMS arrival, SM had the child on a mattress. It was learned that, prior to EMS arrival, SC had been sleeping in his bassinet and on his back. This was an otherwise healthy child with no medical concerns. The SS was at home and was laying down in the living room with SM. The MA and her boyfriend (OA) corroborated the events surrounding the fatal incident. The OA said he heard mom yelling for help around 3:45 and went upstairs to find the events unfolding.

Throughout the investigation, ECDSS made extensive efforts to interview each first responder and diligently documented all casework. ECDSS spoke with all familial collateral contacts and medical personnel. ECDSS requested and reviewed all pertinent medical records for the SC and submitted said records to OCFS for review. ECDSS observed the MGP's home prior to implementing a safety plan and found it to be appropriate. Within three days of making the safety plan, after reviewing the family's history, it was learned the MGP had significant CPS history and was not an appropriate caregiver for the SS. At that time, the MA's home was assessed and deemed safe for the SS to go following MA coming forward as a temporary resource for the SS. ECDSS discussed funeral assistance, grief counseling, and other available resources with the family.

ECDSS unfounded the allegations of IG and DOA/Fatality against the SM regarding the death of the SC as there was no evidence that the SM’s placement of the SC in the bassinet led to the SC’s death. SM reported placing the SC on his back in the bassinet with just a small blanket at his feet. ECDSS indicated allegations of Inadequate Food, Clothing, and Shelter for the SC and SS2. The environment was unsafe due to unsanitary conditions. A safety plan was implemented until the environment was deemed safe for the 2yo SS to return. LE investigated the fatality, but no criminal charges were pursued.

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 completed a thorough investigation and casework 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:
ECDSS conducted a thorough investigation and opened a Preventive Services case to address SM's mental health needs.

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: 07/27/2018 **Time of Death:** Unknown

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: 03:30 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No

Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 2 Hours
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	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Other Household 1	Father	No Role	Male	29 Year(s)

LDSS Response

ECDSS received the report from the SCR on 7/27/18 and coordinated with LE, reviewed the CPS history, and notified the DA's office about the death. Throughout the investigation, collateral contacts were made with the source of the report, personal collaterals for the family, MGM, MGF, MA, first responders, Buffalo Police Homicide Unit, and the preventive services caseworker.

ECDSS assessed the condition of the home to be hazardous for the SS. ECDSS found debris scattered throughout the home. Garbage, dirty diapers, and debris was scattered about the apartment. A safety plan was implemented with input from SM and MGM and the SS went to MGP's home until the SM's could be made safe for the child. ECDSS conducted a thorough check of CPS history and found that the MGP had a history of CPS involvement, including family court action regarding neglect. Due to these concerns, the safety plan was altered to have the SS stay with the MA.

On 7/27/18, ECDSS assessed the safety of the SS who was staying with the MA. The SS received a medical examination at Oishei Hospital at the request of ECDSS as a precautionary measure. The attending physician at Oishei Children's Hospital said the SS was medically examined and found to be healthy with no signs of trauma or abuse.

7/27/18, ECDSS interviewed the SM at the PGM's home. SM said she and the SC woke up at around 7:30AM on 7/27/18. SM made the SC a bottle around 10AM and 12 PM. At 12:30PM SM placed the SC down for a nap in his bassinet. The SM placed the child on his back and his head in a neutral position with a small blanket at the SC's feet. SM said she checked on the SC at 2PM and he "looked fine." SM then went to wake the SC up from the nap at 3:45PM and found the SC to be blue and unresponsive. SM called 911 immediately and began CPR at the direction of the 911 operator. SM said nothing was out of the ordinary leading up to the SC's death and it was typical for the SC to take 4-5-hour naps during the day. SM reported struggling with her mental health and that she was on several different medications to help with symptoms of mental health, but reported it did not impact her ability to care for the SC or SS.

ECDSS spoke with the BF of the SC on 7/28/18. The BF said he was still in shock and processing the death of the SC. BF said that, at the time of death, he had not yet had a visit with the SC and only observed him in the car when the SS was dropped off for visits. The BF did not have any information regarding the SC's death. The BF also has a nine-year-old daughter who resides with his mother. The BF has regular visitation with her there, and she was assessed to be safe with PGM.

On 8/15/18, ECDSS spoke with SM's mental health provider who confirmed SM's attendance and compliance with treatment. Following the phone contact, ECDSS observed the SM's home to be cleaned and meet minimal standards and the SS returned to the home.

ECDSS accurately determined the allegations after conducting a thorough investigation. The safety and risk assessments were fitting to the case circumstances and a 24-hour safety plan was adequately implemented. SM cleaned the home and the SS returned to the home on 8/15/18, ECDSS continued to assess the conditions throughout the remainder of the investigation. Services were offered and accepted. ECDSS closed their investigation and opened a preventive service case with Baker Victory Intensive Services with a protective program choice of prevent placement.

Official Manner and Cause of Death

Official Manner: Accident
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: Erie 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
047581 - Deceased Child, Male, 2 Mons	048148 - Mother, Female, 24 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
047581 - Deceased Child, Male, 2 Mons	048148 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
047581 - Deceased Child, Male, 2 Mons	048148 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
048149 - Sibling, Female, 2 Year(s)	048148 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
048149 - Sibling, Female, 2 Year(s)	048148 - Mother, Female, 24 Year(s)	Inadequate Food / Clothing / Shelter	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: There is an open Preventive Services case as the result of the fatality investigation in order to monitor SM's compliance with MH treatment and ability to maintain a clean and safe home environment for the SS.				

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: Due to the deplorable conditions of the home, 2yo SS was informally placed with the MGP until the home could be deemed safe for the child. Due to circumstances learned during the investigation about the safety of the SS at the MGP's home, child was moved to the home of MA.				

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

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

Additional information, if necessary:
Baker Victory Intensive Preventive Services Program was put in place to assist SM in getting the recommended MH treatment as well as to monitor the conditions of the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Preventive Services were offered and accepted including referrals to community based services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? No
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 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)
04/04/2018	Sibling, Female, 2 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 2 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 9 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Years	Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - BF's girlfriend, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 9 Years	Other Adult - BF's girlfriend, Female, 21 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 2 Years	Other Adult - Unrelated home member, Female, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 9 Years	Other Adult - Unrelated home member, Female, 42 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
BF and his girlfriend (PS) engaged in physical violence in the presence of the SS and an unrelated child. Each adult struck the other. Additionally, the BF and other unrelated adults in the home were abusing marijuana to the point of being too impaired to care for the CHN in the home. The unrelated home member abuses crack to the point of becoming too impaired to care for the CHN.

Report Determination: Unfounded | **Date of Determination:** 09/03/2018

Basis for Determination:
Through home visits, interviews, and collateral contacts it was determined there was no credible evidence to substantiate the allegations of drug and alcohol abuse. There was no credible evidence to indicate domestic violence in this case as all parties denied it and there were no LE records to corroborate the allegations. All relevant collaterals denied concerns of violence in the home.

OCFS Review Results:
ECDSS conducted a thorough investigation, completed timely safety assessments, completed a check of CPS history, and notified all required persons of the existence of a report. Additionally, ECDSS provided safe sleep information to the BF and the BM, who was expecting.

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)
07/27/2017	Sibling, Female, 2 Years	Father, Male, 29 Years	Choking / Twisting / Shaking	Unsubstantiated	Yes
	Sibling, Female, 2 Years	Father, Male, 29 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The report was received on 7/27/17 with concerns that BF grabbed the SS and shook her excessively and yelled at her because the child was crying.

Report Determination: Unfounded	**Date of Determination:** 08/09/2017

Basis for Determination:
There was no evidence to suggest that the BF shook and screamed at the SS. BF allowed LDSS to speak with his employers to confirm that he was at work at the time of the alleged incident. The SS was observed to be free from marks and bruises and appeared to be a healthy child.

OCFS Review Results:
The unfounding was appropriate given the allegations and the circumstances surrounding the investigation. However, ECDSS failed to complete a review of CPS records within the first 24 hours of receipt of the report. Conversations with the SM and BF were lacking key safety-related questions, there was no safety assessment of the BF's other child and it was not known whether that child frequented the home.

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:
Conversations with BF and SM were lacking key safety-related questions with regard to the BF's other child. A child regularly in the home was not added to the report, seen, interviewed nor were the parents spoken to about this child.

Legal Reference:
432.1 (o)

Action:
ECDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation

[redacted]

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

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

Known CPS History Outside of NYS

There is no known 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

We appreciate the opportunity given us to review the draft response in advance. We find the facts, as written, accurately reflect the unfortunate events and actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there were no required actions related to the fatality. However, we unfortunately

must concur with the compliance issues noted by the reviewer with respect to an investigation conducted within the three years preceding the fatality. Namely, with respect to an investigation of the SCR report dated July 27, 2017, we find that, although the review of CPS records was not completed within the first 24 hours of the report, a review was conducted within 48 hours and did include the prior history of the Biological Father of the Subject Child, as it relates to another child of the Biological Father. It appears that the assigned caseworker of the previous investigation should have been aware that the Biological Father may have had regular and ongoing access to or contact with the other child named in the history. In addition, a more comprehensive safety assessment should have been conducted to determine whether that other child should have been added to the report, seen, interviewed, and assessed for safety. ECDSS does agree that there was no documentation that any inquiry into said child was conducted.

With regard to the aforementioned compliance issue, the following corrective action will be implemented:

In a Child Protective Services (CPS) Team Leader meeting to be held on January 15, 2019, a narrative description of the applicable Legal Reference: 432.1 (o), for which ECDSS is out of compliance, will be provided to and will be reviewed with all Team Leaders. The Team Leaders will be instructed to review this compliance issue with their staff in team meetings.

The Legal Reference compliance issue will be recorded and circulated in the Team Leader Meeting minutes of January 15, 2019

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