Child Fatality Report

Report Identification Number: BU-21-020

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

Issue Date: Dec 14, 2021

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 06/24/2021
Initial Date OCFS Notified: 06/25/2021

Presenting Information

An SCR report was received which alleged that on 6/24/21, the father was the sole caretaker of the subject child and his sibling, when at an unknown time, a dresser fell on top of the child. As a result, the child stopped breathing. The father's location during the incident was unknown. The subject child was transported to the hospital via ambulance where he was pronounced dead. There was no explanation as to how the dresser fell on top of the child, and it was unknown if the child was adequately supervised by the father at the time.

Executive Summary

This fatality report concerns the death of a one-year-old male subject child that occurred on 6/24/21. A report was registered with the SCR on 6/25/21 with allegations of Inadequate Guardianship, Lack of Supervision and DOA/Fatality against the child's father. Erie County Department of Social Services (ECDSS) received the report and investigated the child's death. An autopsy was completed; however, the final report had not yet been released at the time of this writing. A preliminary report noted the cause of death as asphyxia and the manner as accidental.

At the time of the child's death, he resided with his father and two-year-old sibling. The child's mother resided in a separate residence with four surviving half-siblings, ages one month old, eight, seven, and six years old. Two additional half-siblings were in the care and custody of their paternal grandparents; their ages were not documented in the case record. The investigation revealed that on the evening of 6/24/21, the father was at home with the subject child and his sibling, and the children were playing in their bedroom while the father was elsewhere in the home. At approximately 5:00PM, the father heard a noise coming from the bedroom and found that the dresser and television had fallen over; the children appeared unharmed and were playing on the bed. The father did not pick up the dresser from where it fell onto the floor. The children napped for about one hour, and at 6:30PM, the father ordered food for delivery. The father checked on the children at that time and they were awake, again playing on the bed in their bedroom. At 6:51PM, the father's food arrived. He went into the children's bedroom after retrieving the food and found the subject child partially inside one of the dresser drawers, unresponsive; the dresser drawer was pressed into the child's neck. The father removed the child from the drawer, called emergency services, and began cardiopulmonary resuscitation. The child was transported to the local hospital via ambulance, where he was pronounced deceased at 7:52PM on 6/24/21.

ECDSS assessed the safety of the surviving children and no concerns were noted. Collateral sources were interviewed, which included law enforcement, hospital staff, medical professionals, the children's pediatricians, and schools. A neglect petition was filed against the father, and the mother was granted emergency custody of the sibling. Law enforcement and the medical examiner noted concerns surrounding the father's timeline of events and concluded the father had left the children unsupervised for longer than he had said. The father's lack of supervision of the children led to the death of the subject child, therefore, ECDSS substantiated all allegations in the fatality report. The father had not been charged with the death of the child at the time of this writing, and a court ordered services case was opened and ongoing. The investigation was indicated and closed.

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 information to determine the allegations and assess the safety of the surviving sibling and half-siblings.

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 record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

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: 06/24/2021 **Time of Death:** 07:52 PM

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? 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? No - but needed

At time of incident was supervisor impaired? Not impaired.

At time of incident supervisor was:

- ☒ Distracted
- ☒ Absent
- ☐ Asleep
- ☐ 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	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)

LDSS Response

On 6/25/21, ECDSS received the SCR report regarding the death of SC, which occurred on 6/24/21. EDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team.

On the date the report was received, ECDSS met with BM and the 4 half-siblings in her care. BM reported she had not seen SC or SS in over a year because SF would not allow her to see them. BM said PA called her around 9:00PM on 6/24/21 and told her what happened. BM had no additional information about the incident. The verbal half-siblings were interviewed and denied any safety concerns. ECDSS reviewed safe sleep with BM, and all 4 CHN were deemed safe.

ECDSS made efforts to locate SF and SS upon receipt of the report but were unsuccessful until 6/27/21. A home visit was scheduled, and on 6/27/21, ECDSS met with SF and SS at a relative's home where they were staying. SF refused to engage in an interview; however, SS was observed and deemed safe. Relatives in the home were assisting SF with SS's care while he grieved.

On 6/28/21, ECDSS spoke with LE to obtain information from their interview with SF. LE stated SF was at home with SC and SS on 6/24/21, and at 5:00PM, he heard a noise in the bedroom where the CHN were. SF checked on the CHN and found the dresser and TV in the room had fallen over, and the CHN playing on the bed. SF said he felt it was safer to leave the dresser on the floor, so he did not pick it up. He then put the children down for a nap and they slept until 6:00PM. SF explained when they awoke, they again were playing in their room. SF said he ordered food at 6:30PM, and checked on the CHN at that time, who were fine. SF said the food was delivered at 6:51PM, and when he went in the room to bring the CHN dinner, he found SC trapped in the dresser. SF pulled SC out, but he was unresponsive. SF called 911 and CPR was administered. LE stated SF claimed to have seen the CHN a few minutes prior to the food delivery; however, they feel SF

had left the CHN unsupervised for longer than he said. LE stated they attempted a reenactment and believed what happened was accidental: the dresser was angled against the wall with the drawers partially out, SC crawled up and into a drawer where he got stuck inside. LE said SF retained a lawyer and would not answer further questions. LE found marijuana in SF's home, but it was later determined SF had a valid medical marijuana card.

On 6/30/21, ECDSS spoke with SF via phone, who reiterated what he had told LE. SF clarified he found SC face down with his head and part of his body inside one of the dresser drawers. He stated SS had also been inside a drawer, but he came out when SF entered the room.

On 6/30/21, the family appeared in court. BM was granted custody of SS, and an order of supervision was issued.

Throughout the investigation, ECDSS assessed the safety of all 6 surviving half-siblings and SS. The 2 half-siblings residing with their paternal grandparents were interviewed and there were no concerns. All CHN were seen medically and cleared. Concerns received in subsequent reports surrounding BM and physical aggression by her boyfriend were investigated thoroughly. It was determined the boyfriend did not reside in the home, but the CHN witnessed him physically assault BM on several occasions. The boyfriend was incarcerated during this investigation and BM obtained a full stay away OP against him. There were no safety concerns noted by any collateral sources regarding the CHN. The ME stated SF's story is plausible and a preliminary cause of death was asphyxia. ME agreed SF probably left the CHN unsupervised longer than he said based on rigor mortis; however, the line on SC's neck was consistent with a drawer. A neglect petition was filed against SF and court ordered services case was opened on his behalf. BM was offered DV services, but declined. There were no criminal charges filed, and the investigation was indicated and closed.

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
Comments: This fatality investigation was conducted by the Erie County MDT.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was submitted for review by the Erie County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059021 - Deceased Child, Male, 1 Yrs	059022 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
059021 - Deceased Child, Male, 1 Yrs	059022 - Father, Male, 26 Year(s)	Lack of Supervision	Substantiated
059021 - Deceased Child, Male, 1 Yrs	059022 - Father, Male, 26 Year(s)	DOA / Fatality	Substantiated
059023 - Sibling, Male, 2 Year(s)	059022 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
059023 - Sibling, Male, 2 Year(s)	059022 - Father, Male, 26 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐

Additional information:

ECDSS interviewed the family and collateral sources. Progress notes and other documentation were completed and entered within the required timeframes.

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: A court ordered services case was opened in response to the concerns that arose during the fatality investigation.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: Following the fatality, the mother filed for, and was awarded emergency custody of the surviving sibling.				

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:**
06/30/2021	There was not a fact finding	Order of Supervision
Respondent:	059022 Father Male 26 Year(s)	
Comments:	A neglect petition was filed against the father following the death of the subject child due to concerns surrounding lack of supervision. The mother was awarded emergency custody of the surviving sibling, and an order of supervision was issued where the father would have supervised visitation only. A court ordered services case was opened and family court proceedings remained ongoing at the time of this writing.	

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Court Ordered Services

Additional information, if necessary:
Services were offered to the mother following the death of the child, but declined. A court ordered services case regarding the father was opened to further address concerns that arose during the fatality investigation.

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:
ECDSS provided the parents with referrals for grief and bereavement counseling for the surviving sibling and half-siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ECDSS provided grief and bereavement referrals to the parents. Additionally, a services case was opened in response to the fatality.

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? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/02/2021	Sibling, Female, 8 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 7 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 5 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 4 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 3 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 8 Years	Mother, Female, 29 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 29 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 29 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 7 Years	Mother, Female, 29 Years	Poisoning / Noxious Substances	Unsubstantiated	
	Sibling, Female, 8 Years	Other Adult - BF of 4 and 3yo SSs, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 7 Years	Other Adult - BF of 4 and 3yo SSs, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 5 Years	Other Adult - BF of 4 and 3yo SSs, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 4 Years	Other Adult - BF of 4 and 3yo SSs, Male, 31 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Substantiated	
	Sibling, Male, 7 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 5 Years	Mother's Partner, Male, 30 Years	Inadequate Guardianship	Substantiated	

Deceased Child, Male, 1 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 2 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 8 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 7 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 5 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 4 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Father, Male, 26 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
This SCR report was received with concerns that on more than one occasion, BM had become physically aggressive with the 7 and 8-year-old half-siblings. As a result, they sustained marks and were fearful of the mother. Further, the mother's boyfriend physically assaulted the mother in the presence of the children, and the mother had a history of selling drugs out of the home with the BF of the 4yo. There was an incident where BF tried to run someone over while the CHN were in the car, and there were concerns the 7yo CH ate paint chips when he was 1 and was later diagnosed with autism.

Report Determination: Indicated | **Date of Determination:** 02/03/2021

Basis for Determination:
The 8yo disclosed BM locked her in her room as punishment for 2 minutes. 8yo said BM disciplined her with an open hand and left marks. ECDSS did not observe any marks during any contacts with the CH. Appropriate discipline was discussed with BM. The 7yo denied physical discipline and denied seeing the 8yo hit by BM. The CHN disclosed physical aggression by BM's boyfriend toward BM. There was no evidence found regarding drug sale, or the 7yo eating paint chips. Collaterals, including the CHN's pediatrician, had no concerns. BF reported an incident where a woman jumped on the hood of his car; none of the CHN were there. BM obtained an OP against her boyfriend and the CHN were deemed safe.

OCFS Review Results:
This investigation met all statutory requirements.

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)
10/22/2020	Deceased Child, Male, 8 Months	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 8 Months	Mother, Female, 29 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
This SCR report was received with concerns SC was born breech, which caused him to have issues with his hips. BM was aware but failed to follow through with medical attention to address the issue. As a result, SC's motor skills were delayed. In July 2020, BM decided she no longer wanted to care for SC or SS and dropped them off at SF's home. SF applied for custody of both CHN.

Report Determination: Unfounded | **Date of Determination:** 12/15/2020

Basis for Determination:
ECDSS interviewed family and collaterals. BM reported it was a mutual agreement for SF to take the CHN after she and SF broke up in July 2020. BM denied the allegations. No safety concerns were disclosed by the CHN. Parents were educated regarding safe sleep. SC's pediatrician confirmed an ultrasound of SC's hips was completed shortly after his birth; there was no hip condition found and SC was not developmentally delayed. The record did not reflect the other CHN or SS had any medical issues which needed to be addressed.

OCFS Review Results:
This investigation met all statutory requirements.

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)
03/04/2020	Deceased Child, Male, 9 Days	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 3 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 9 Days	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 2 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 28 Years	Educational Neglect	Unsubstantiated	
	Sibling, Female, 7 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 28 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 28 Years	Educational Neglect	Unsubstantiated	
	Sibling, Female, 4 Years	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Father, Male, 25 Years	Educational Neglect	Unsubstantiated	
	Sibling, Female, 7 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Father, Male, 25 Years	Educational Neglect	Unsubstantiated	

Sibling, Male, 6 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 4 Years	Father, Male, 25 Years	Educational Neglect	Unsubstantiated
Sibling, Female, 4 Years	Father, Male, 25 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
This SCR report was received with concerns the 8yo half-sibling was absent from school 24 days, and the 7yo was absent for 30 days. As a result, their education was negatively impacted. BM was aware of the issue and did not intervene. The home was in deplorable conditions and infested with rats. One of the children was almost bitten by a rat.

Report Determination: Unfounded | **Date of Determination:** 03/18/2020

Basis for Determination:
ECDSS spoke with family members and collaterals. The school reported the attendance issue for the 8yo was the year prior and she was doing better for the current year. The 7yo was struggling with attendance but school was out due to COVID-19 so the issue could not be resolved. BM provided copies of notes to the school when the CHN were ill. None of the CHN were being held back and they were deemed safe. The home was not deplorable, and no rats were observed. The 8yo reported seeing a rat in the hallway, but not in the apartment. The parents were educated surrounding safe sleep and provisions were observed.

OCFS Review Results:
This investigation met all statutory requirements.

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

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

From 2014 to 2018, the mother was listed as a subject in three CPS investigations with common allegations of LS, IG, IF/C/S and P/Nx. OF these three investigations, two were indicated.

In 2016, the father was listed as a subject in one CPS investigation with allegations of IG and CD/AM. This investigation was unfounded.

In 2015, the seven and eight-year-old surviving half-siblings were listed as maltreated children in one CPS investigation with allegations of IG against their biological father. This investigation was unfounded.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

On 12/11/14, a court ordered services case was opened involving the mother, seven and eight-year-old half-siblings, and their biological father after concerns arose regarding the biological father physically assaulting the mother in the presence of the children. There were further concerns the parents were not complying with an active order of protection. ECDSS and family court supervision successfully ended on 6/4/16. The parents were cooperative, completed their court orders, and maintained the safety of the children. The services case was closed on 6/6/16.

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 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