Child Fatality Report

Report Identification Number: BU-22-021

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

Issue Date: Mar 08, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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 year(s)
Jurisdiction: Wyoming
Gender: Male
Date of Death: 09/14/2022
Initial Date OCFS Notified: 09/14/2022

Presenting Information

An SCR report alleged that on 9/14/22 around 7:30AM, the aunt and uncle checked on the 2-year-old male subject child while he was sleeping. The child was breathing at that time. Around 11:45AM, the aunt checked on the child again and found him deceased in his bed. Emergency medical services were contacted and arrived at the home and confirmed that the child was deceased. It was unknown if lifesaving measures were performed. On an unknown date approximately one year prior to the SCR report, the mother shook the child for unknown reasons. The child sustained unspecified injuries that required further medical intervention following that incident.

Executive Summary

On 9/14/22, the Wyoming County Department of Social Services (WCDSS) received an SCR report regarding the death of the 2-year-old child that occurred on the same date. The report alleged DOA/Fatality and Inadequate Guardianship against the aunt and uncle and Choking/Twisting/Shaking and Inadequate Guardianship against the mother. WCDSS added the allegations Inadequate Food/Clothing/Shelter and Choking/Twisting/Shaking against the father.

At the time of the death, the child lived with his maternal aunt, uncle, the 3-year-old sibling, 11-year-old cousin, and 8-month-old cousin. The mother and father had an open services case through the Erie County Department of Social Services (ECDSS) at the time of the child's death due to a history of unstable housing and concerns for the mother's mental health. The mother had four children, ages 1, 3, 4, and the 2-year-old subject child. The 4-year-old was in Article 6 custody of the paternal grandmother, the 3-year-old sibling and subject child were in a 1017 Direct Placement with the maternal aunt, and the 1-year-old sibling was in foster care. The subject child was placed with the maternal aunt after it was discovered he suffered from shaken baby syndrome and there were concerns for his nutritional intake while in the care of the parents.

WCDSS learned of the death of the subject child and immediately began gathering information related to the incident. It was learned that on 9/14/22, the aunt got up with the 3-year-old sibling and got him ready for school. The aunt checked on the child and it appeared he was still sleeping. Throughout the morning, the uncle and his brother were home installing a new washer and dryer. The uncle believed that the child was playing in his room. The aunt was lying down after bringing the sibling to school. At 11:30AM, the uncle went to check on the child and observed him lying in bed. The uncle sat near the child and rubbed his back. The uncle realized the child was cold and turned him over to find him purple and unresponsive. The uncle yelled for the aunt, who called 911 and the uncle began cardiopulmonary resuscitation. Law enforcement arrived and the child was already deceased upon their arrival.

An autopsy was completed and WCDSS documented that during a conversation with the medical examiner, it was stated there was a possibility the death of the child was related to the head trauma he experienced due to being shaken by the parents as an infant. The preliminary findings showed no signs of obvious abuse or maltreatment; however, the final results were pending. There was no concern by law enforcement that the aunt or uncle inflicted any harm upon the child resulting in his death and their investigation was closed.

Within 24-hours of the SCR report, WCDSS implemented a safety plan due to the unexplained nature of the death of the child. The plan required the aunt and uncle to have supervised contact with the other children in their home. WCDSS spoke to the medical examiner, who reported that the initial findings showed no obvious signs of neglect or abuse and the safety plan was ended on 9/27/22. The cousins and siblings remained in the care of their respective caretakers and were

determined to be safe.

WCDSS offered the aunt, uncle, and paternal grandmother grief counseling services. The record did not reflect the parents were offered services related to the fatality. The allegations against the aunt and uncle were unsubstantiated, as there was no evidence gathered to support their actions contributed to the death. The allegations against the parents were substantiated due to them being substantiated in a past investigation regarding the head injury that the child sustained as a result of shaken baby syndrome. The CPS investigation was indicated and the family remained open with preventive and foster care services.

PIP Requirement
OCFS' review resulted in citations. In response, each cited county will submit a Program Improvement Plan (PIP) to the Regional Office which will identify what action(s) the respective LDSS' have taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, the respective LDSS will review the plan(s) and revise as needed to further address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
WCDSS made an appropriate determination given the information gathered. The preventive and foster care case remained open with ECDSS.

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

Explain:
Although all other casework activity was commensurate with case circumstances, the record did not reflect the father

was notified of the report in writing.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	Although all other adults were provided with notification of existence letters, the record did not reflect the father was provided with notice of the SCR report in writing.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	WCDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	WCDSS observed guns that were accessible to the children at the aunt and uncle's home. WCDSS made law enforcement aware of this; however, the record did not reflect if there was follow up to confirm the issue with the guns was addressed.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	WCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.
Issue:	Adequacy of services following the fatality
Summary:	Though grief counseling were offered to the aunt and uncle, the record did not reflect services were offered on behalf of the 11yo cousin, who expressed sadness, guilt and grief over the death of the subject child.
Legal Reference:	18 NYCRR 432.2(b)(4);428.6
Action:	WCDSS will explore areas of potential service needs with all family members with whom they are involved. WCDSS will appropriately respond to changing circumstances, and if service needs are identified, WCDSS will make the appropriate referral to preventive or community-based services in an effort to determine whether there are services that can benefit the family.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/14/2022 **Time of Death:** Unknown

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

County where fatality incident occurred: Wyoming
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 and/or ingested alcohol or drugs? No

Child's activity at time of incident:

- [x] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [ ] Playing
- [ ] Eating
- [ ] Unknown
- [ ] 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	Aunt/Uncle	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	8 Month(s)
Deceased Child's Household	Other Child - Cousin	No Role	Male	11 Year(s)
Deceased Child's Household	Other Child - Cousin	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Grandparent	No Role	Female	54 Year(s)
Other Household 1	Sibling	No Role	Male	4 Year(s)
Other Household 2	Father	Alleged Perpetrator	Male	30 Year(s)
Other Household 2	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 3	Sibling	No Role	Male	1 Year(s)

LDSS Response

Upon receipt of the SCR report on 9/14/22, WCDSS initiated their investigation, coordinated efforts with law enforcement, spoke to the Assistant District Attorney, completed home visits, assessed the safety of the surviving children, and interviewed the parents and relatives.

WCDSS interviewed the aunt and uncle together at their home. On the evening of 9/13/22, the aunt and uncle gave the child a bath, got the child and 3yo sibling ready for bed, and read them a book. There were no concerns with the child at the time they put him to sleep. On 9/14/22, the aunt checked on the child at 7:30AM, and thought he was sleeping. The aunt got the sibling ready for school. The uncle and his brother were home installing a new washing machine and dryer. The uncle thought the child was playing in his room and the aunt was lying back down in bed. The uncle checked on the child at 11:30AM. The child was still in bed so the uncle sat at the edge of the bed rubbing the child's back. The uncle felt the child was cold and turned him over and saw he was purple. The uncle yelled for the aunt. The aunt called 911 and the uncle performed CPR on the child until first responders arrived to the home.

WCDSS interviewed the verbal surviving children at the Child Advocacy Center. The aunt had a 14yo child who resided with her father. She was interviewed and reported spending very little time at the aunt's home. She was assessed to be safe with her father. The 11yo cousin reported no safety concerns in the home or concerns for the child. The parents were

interviewed and reported that the last time they saw the child he appeared to be a happy healthy baby.

WCDSS and ECDSS completed visits to the 1-year-old sibling's daycare, the paternal grandmother's home, the 14yo cousin's father's home, and the aunt and uncle's home. At the aunt and uncle's home there were guns unable to be locked in the locked gun cabinet. WCDSS made law enforcement aware of this; however, the record did not reflect if there was follow up to confirm the issue with the guns was addressed. There were no other concerns for the surviving children.

The record reflected that WCDSS requested records from the child's specialists, including neurology and the opthamologist. The records were not received by WCDSS during the investigation. The child's pediatric records showed he was last seen on 8/4/22 and there were no concerns reported for his care. The open services case indicated that the aunt provided ECDSS with updates regarding the child's medical care. The record did not reflect contact with the child's specialists since he was placed with the aunt; however, the aunt and uncle report the child finished his follow-up care for shaken baby syndrome in July 2022 and he was doing well. There were no concerns for the medical care of the other children.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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 referred to an OCFS approved Child Fatality Review Team? No
Comments: WCDSS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062541 - Deceased Child, Male, 2 Yrs	062548 - Mother, Female, 23 Year(s)	Choking / Twisting / Shaking	Substantiated
062541 - Deceased Child, Male, 2 Yrs	062548 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
062541 - Deceased Child, Male, 2 Yrs	062542 - Aunt/Uncle, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
062541 - Deceased Child, Male, 2 Yrs	062542 - Aunt/Uncle, Female, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
062541 - Deceased Child, Male, 2 Yrs	062543 - Aunt/Uncle, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
062541 - Deceased Child, Male, 2 Yrs	062543 - Aunt/Uncle, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
062541 - Deceased Child, Male, 2 Yrs	062551 - Father, Male, 30 Year(s)	Choking / Twisting / Shaking	Substantiated
062541 - Deceased Child, Male, 2 Yrs	062551 - Father, Male, 30 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:

The record did not reflect attempted contact with emergency medical services.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

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

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

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
The 14yo cousin was already enrolled in mental health counseling. Grief counseling was discussed with the aunt and uncle; however, after WCDSS learned the 11yo cousin was experiencing sadness and grief over the death, services for the cousin were not discussed with the aunt and uncle.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Although WCDSS provided the aunt and uncle with information on grief counseling services, the record did not reflect the child's parents were offered grief counseling services.

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? Yes
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)
06/13/2022	Sibling, Male, 4	Grandparent, Female, 53	Inadequate Food / Clothing /	Unsubstantiated	Yes

Years	Years	Shelter	
Sibling, Male, 4 Years	Grandparent, Female, 53 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 4 Years	Grandparent, Female, 53 Years	Lack of Medical Care	Unsubstantiated
Sibling, Male, 4 Years	Grandparent, Female, 53 Years	Lack of Supervision	Unsubstantiated

Report Summary:
Erie County Department of Social Services (ECDSS) received an SCR report that stated the PGM was unable to manage the 4yo SS due to his behaviors and developmental disability. The PGM would become angry with the child, hit him, push him to the floor and lock him in his bedroom at night. The condition of the home was a concern, as there were boxes stacked five feet high, sixteen animals, feces on the floor and on the wall, and fumes from the feces as well as bacteria. The sibling was sick because of the home's condition and had not received medical care. There were concerns for the SS's supervision, allowing him access to the unsafe conditions.

Report Determination: Unfounded | **Date of Determination:** 08/05/2022

Basis for Determination:
ECDSS determined through home visits and interviews with all relevant parties and collateral contacts, that there was not a fair preponderance of evidence to substantiate the allegations against the PGM. The pediatrician had no concerns for the sibling. The PGM removed a lock on the SS's door after ECDSS pointed out that it was a fire hazard. LE reported no safety concerns in the home. ECDSS observed the home to meet minimum standards and it was not as described in the SCR report. The home had appropriate provisions for the SS. There were no marks and bruises on the SS. The family remained open with ongoing services.

OCFS Review Results:
ECDSS visited the grandmother's home and determined the condition was not as described in the SCR report. The sibling was non-verbal due to a developmental disability and was unable to be interviewed. ECDSS interviewed the grandmother, parents, and several collaterals. There were no concerns expressed for the the care of the sibling. Although ECDSS documented a history check, it was completed late on 7/19/22.

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

Issue:
Review of CPS History

Summary:
ECDSS documented the CPS history check late on 7/19/22.

Legal Reference:
18 NYCRR 432.2(b)(3)(i)

Action:
Within 1 business day of a report, ECDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, ECDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/26/2021	Sibling, Male, 3 Years	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 3 Years	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	

Sibling, Male, 3 Years	Grandparent, Female, 52 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Grandparent, Female, 52 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 3 Years	Grandparent, Male, 51 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Grandparent, Male, 51 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 3 Years	Aunt/Uncle, Male, 21 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Aunt/Uncle, Male, 21 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 3 Years	Unrelated Home Member, Female, 24 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Unrelated Home Member, Female, 24 Years	Lacerations / Bruises / Welts	Unsubstantiated

Report Summary:
Erie County Department of Social Services (ECDSS) received an SCR report that alleged the then 3-year-old sibling sustained small bruises on his upper right arm and chest while in the grandmother's home. The grandmother, grandfather, uncle and unrelated home member were all regular caregivers for the sibling in the home. There was no consistent explanation for the bruises, and they appeared to have been inflicted onto the sibling in some manner. The roles of the biological parents were unknown.

Report Determination: Indicated | **Date of Determination:** 11/26/2021

Basis for Determination:
ECDSS added the allegation IG against the parents regarding the SS and determined that there was credible evidence to support the allegation. The paternal grandparents and the parents had joint custody of the SS. Due to the SC being removed and the severity of the injuries to the SC, ECDSS determined the SS was derivatively abused and filed a Derivative Abuse Petition against the parents. The allegations against the other adults were unsubstantiated. ECDSS found the home had ample food and the provisions for the SS. The SS was in receipt of medical care and his injuries were consistent with accidental marks and bruises due to his age and activity level.

OCFS Review Results:
Prior to the SCR report, the parents were minimally visiting the then 3yo SS. During the investigation, the parents started exercising their unsupervised visits with the SS. There was concern for the unsupervised contact, due to the circumstances that led to the Abuse Petition regarding the subject child. ECDSS filed a Derivative Abuse Petition regarding the sibling. The Judge granted a 1017 placement of the SS with the paternal grandmother and the parents were given supervised visits. ECDSS completed all casework activity commensurate with case circumstances.

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)
06/30/2021	Sibling, Male, 1 Days	Mother, Female, 22 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Male, 1 Days	Father, Male, 29 Years	Inadequate Guardianship	Substantiated	

Report Summary:
Erie County Department of Social Services (ECDSS) received an SCR report that alleged on 6/30/21, the mother gave birth to the 1-day-old sibling. At the time of the sibling’s birth, the parents did not have custody of their other children due to concerns of abuse and neglect. The children had not been returned to the care of the mother and father. As a result,

there was a concern for their ability to care for the newborn sibling. The subject child was removed due to shaken baby syndrome and it was unknown why the mother's other three children were removed.

Report Determination: Indicated | **Date of Determination:** 06/30/2021

Basis for Determination:
ECDSS determined there was credible evidence to substantiate the allegation against the parents. The parents had a pending Abuse Petition due to injuries the subject child sustained that were consistent with shaken baby syndrome. ECDSS filed a Derivative Abuse Petition with respect to the sibling on 7/2/21 and the child was placed in foster care. The case remained open with ongoing services.

OCFS Review Results:
ECDSS initiated the SCR report within 24 hours, interviewed the parents, spoke to relatives, and saw the sibling throughout the investigation. ECDSS reviewed safe sleep guidance and the sibling had appropriate provisions. CPS spoke with the ongoing services caseworker throughout the investigation. Notification letters were provided to the parents. There was supervisory and legal consultations documented within the investigation.

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)
12/09/2020	Deceased Child, Male, 5 Months	Mother, Female, 21 Years	Choking / Twisting / Shaking	Substantiated	No
	Deceased Child, Male, 5 Months	Mother, Female, 21 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 5 Months	Mother, Female, 21 Years	Internal Injuries	Substantiated	
	Deceased Child, Male, 5 Months	Mother, Female, 21 Years	Swelling / Dislocations / Sprains	Substantiated	
	Deceased Child, Male, 5 Months	Father, Male, 28 Years	Choking / Twisting / Shaking	Substantiated	
	Deceased Child, Male, 5 Months	Father, Male, 28 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 5 Months	Father, Male, 28 Years	Internal Injuries	Substantiated	
	Deceased Child, Male, 5 Months	Father, Male, 28 Years	Swelling / Dislocations / Sprains	Substantiated	
	Deceased Child, Male, 5 Months	Father, Male, 28 Years	Lacerations / Bruises / Welts	Substantiated	

Report Summary:
Erie County Department of Social Services (ECDSS) received an SCR report that alleged on or around 9/13/20, the then 5-month-old child was in the sole care of the father. The father shook the child for unknown reasons. The child sustained bleeding on both sides of his brain, blood in his right eye socket, bruising on the forehead, and significant swelling as a result. The mother and the aunt had unknown roles.

Report Determination: Indicated | **Date of Determination:** 01/13/2021

Basis for Determination:
ECDSS found there was credible evidence to substantiate the allegations against both parents and added allegations against the mother. The child had a supratentorial subdural hemorrhage and a left side subdural hemorrhage, an injury consistent with shaken baby syndrome. The parents reported that they had been the only ones to care for the child. The child was seen on multiple other dates, presenting with an illness and weight loss. The parents admitted to not feeding the

child on a schedule and not waking the child up to eat. An Abuse Petition was filed against the parents. The child was removed from the parents' care and was placed in 1017 custody of the aunt.

OCFS Review Results:
ECDSS investigated the same allegations in the 9/14/20 SCR report. ECDSS interviewed the parents, spoke to collaterals, and obtained necessary records. The child was placed with the aunt at the time of the SCR report and was determined to be safe. ECDSS reviewed safe sleep guidance with the parents and aunt. The family remained open with ongoing 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)
09/14/2020	Deceased Child, Male, 2 Months	Mother, Female, 21 Years	Choking / Twisting / Shaking	Substantiated	Yes
	Deceased Child, Male, 2 Months	Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Deceased Child, Male, 2 Months	Mother, Female, 21 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 2 Months	Father, Male, 28 Years	Choking / Twisting / Shaking	Substantiated	
	Deceased Child, Male, 2 Months	Father, Male, 28 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Deceased Child, Male, 2 Months	Father, Male, 28 Years	Inadequate Guardianship	Substantiated	

Report Summary:
Erie County Department of Social Services (ECDSS) received an SCR report that alleged the mother and father were the primary caregivers of the then 2-month-old subject child. The child had a 4mm-8mm right supratentorial subdural hemorrhage and a left side subdural hemorrhage, which showed that the child was significantly shaken, on more than one occasion. The child presented as lethargic and over the past two months, consistently lost weight, showing that the mother and father failed to adequately feed him. As a result of the parents' actions, the child has sustained substantial injuries that would have permanent lasting effects on his development.

Report Determination: Indicated | **Date of Determination:** 01/08/2021

Basis for Determination:
ECDSS found there was credible evidence to substantiate the allegations against the parents. The child presented to the hospital suffering from a 4mm-8mm right supratentorial subdural hemorrhage and a left side subdural hemorrhage, an injury consistent with shaken baby syndrome. The parents reported that they had been the only ones to care for the child. The child was seen on multiple other dates, presenting with an illness and weight loss. The parents admitted to not feeding the child on a schedule and not waking the child up to eat. An Abuse Petition was filed against the parents. The child was removed from the parents' care and was placed in 1017 custody of the aunt.

OCFS Review Results:
ECDSS initiated a joint investigation with law enforcement upon receipt of the SCR report. ECDSS interviewed the parents, spoke to collaterals, and obtained necessary records. ECDSS inquired about the status of the child throughout the investigation. The child was removed and placed with a relative. ECDSS assessed the child's home and reviewed safe sleep guidance. There was a safety concern that came up during the investigation that was addressed at that time; however, the record did not reflect there was follow-up. The CPS history check was documented late on 1/4/21. There were several notes documented a month after their event dates.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
The record reflected that approximately 19 out of 67 progress notes were entered more than a month after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Issue:
Review of CPS History
Summary:
The CPS history check was documented late on 1/4/21.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, ECDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, ECDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The aunt and uncle had guns and ammo accessible to the children in their home. ECDSS asked them to lock the ammo and requested a photo of this being completed be sent to ECDSS. The record did not reflect this was further discussed or addressed.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
Prior to making a determination, ECDSS shall include an assessment of the current safety and the risk of future abuse and maltreatment to the child(ren) in the home and documenting such assessment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/13/2020	Deceased Child, Male, 2 Months	Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 2 Months	Mother, Female, 21 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 2 Months	Mother, Female, 21 Years	Malnutrition / Failure to Thrive	Substantiated	
	Deceased Child, Male, 2 Months	Father, Male, 28 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 2 Months	Father, Male, 28 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 2	Father, Male, 28	Malnutrition / Failure to	Substantiated	

	Months	Years	Thrive		

Report Summary:
Erie County Department of Social Services (ECDSS) received an SCR report that stated the mother and father were not able to adequately care for the then 2-month-old subject child. The child had not eaten in six hours and lost one pound in three days. The child did not wear adequate clothing and was in only a diaper and cold. The child sat in a soaked dirty diaper for a long period of time.

Report Determination: Indicated | **Date of Determination:** 12/13/2020

Basis for Determination:
ECDSS substantiated the allegations of IG and M/FTTH against the parents. Through interviews with relevant parties and collateral contacts ECDSS determined there was credible evidence to substantiate the allegations. The mother refused to speak to CPS during the investigation. The child was taken to the hospital, and it was determined he had lost a pound. The child was sick, but it was reported that would not have resulted in weight loss. The parents reported not feeding the child in the six hours prior to bringing the child to the hospital. The child was admitted to the hospital where it was learned that child suffered a skull fracture, and a separate SCR report was made.

OCFS Review Results:
ECDSS initiated the investigation within 24 hours of receipt of the SCR report. The father was interviewed and ECDSS attempted to interview the mother regarding the SCR report on 12/8/20; however, she refused. ECDSS made contact with medical collaterals and learned the child had lost one to two pounds in two days and was failure to thrive. Additional concerns regarding non-accidental trauma were discovered and the child was removed and placed with the maternal aunt. The record did not reflect that notification letters were provided or a CPS history check was completed.

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

Issue:
Failure to provide notice of report

Summary:
The record did not reflect the parents were provided with written notice of existence of the SCR report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
ECDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

Issue:
Failure to Provide Notice of Indication

Summary:
The record did not reflect that the parents were notified of the determination of the report in writing.

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

Action:
When an SCR report is determined to be indicated, ECDSS must deliver or mails to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/05/2020	Deceased Child, Male, 2 Days	Mother, Female, 21 Years	Inadequate Food / Clothing / Shelter	Substantiated	No

Deceased Child, Male, 2 Days	Mother, Female, 21 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 2 Days	Father, Male, 28 Years	Inadequate Food / Clothing / Shelter	Substantiated
Deceased Child, Male, 2 Days	Father, Male, 28 Years	Inadequate Guardianship	Substantiated

Report Summary:
Erie County Department of Social Services (ECDSS) received an SCR report that alleged the mother gave birth to the subject child on 7/3/20. The mother and father had two other children removed from their care due to abuse and neglect. The parents were aware the child needed to be fed every three hours and awoken to feed if asleep. The parents failed to follow the scheduled feedings. As a result, the child was displaying signs of hunger and was not passing stool and/or urine as he should and lost weight. Intervention was required to ensure the child was being fed regularly. Neither parent responded to the child’s needs as they should have.

Report Determination: Indicated | **Date of Determination:** 08/19/2020

Basis for Determination:
The allegations against the mother and father were substantiated. It was determined the parents had previous children who were removed from their care due to unstable housing. The parents had a history of unstable housing and had 3-4 addresses in the past six months. The parents were temporarily living at a family shelter. The parents had food and bedding that was appropriate for the subject child. A Neglect Petition was filed against the parents and the judge ordered court-ordered supervision and the family was opened to services.

OCFS Review Results:
ECDSS initiated the SCR report within 24 hours, interviewed the parents, spoke to relatives, and saw the subject child throughout the investigation. ECDSS reviewed safe sleep guidance and the child had appropriate provisions. A Neglect Petition was filed regarding the parents' chronic lack of stable housing and the family was opened to preventive services. The parents were in the process of applying for ECDSS housing assistance at the closure of the investigation. Safety Assessments were completed on time and with accurate information. Notification letters were provided to the parents. There was supervisory and legal consultations documented within the investigation.

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

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

In 2012, the father was substantiated for XCP and IG after he hit and threw his then girlfriend's child to the floor. ECDSS filed a Neglect Petition against the father and there was an OP regarding that child until the child turned 18-years-old. The father was removed from the case after the father's relationship with the girlfriend ended.

In 2017, there was an indicated CPS investigation in Erie County with a substantiated IG allegation against the paternal grandmother regarding the 4-year-old sibling.

In 2017, the uncle and cousin's father each had an unfounded CPS investigation in Wyoming County regarding the cousins.

In 2018, there was an unfounded CPS investigation in Erie County with unsubstantiated IG and PD/AM allegations against the mother regarding the 4-year-old sibling. During the investigation, the paternal grandmother was awarded custody of the sibling.

In 2019, there was an indicated CPS investigation in Niagara County with substantiated IG and IF/C/S allegations against the mother regarding the 3-year-old sibling.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

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: 07/09/2020

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: 07/09/2020

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
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?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☒	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine

Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: ECDSS implemented Wraparound services for service coordination.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☒Yes ☐No

Issue:	Failure to Monitor
Summary:	The record did not reflect that there was a CPS monitor assigned to the case.
Legal Reference:	18 NYCRR 432.2(b)(5)
Action:	CPS is responsible for monitoring the provision of services, including foster care services, to children named in open indicated abuse and maltreatment reports and their families, when the CPS worker is not the primary service provider for the case.
Issue:	Adequacy of case recording in FASP
Summary:	In the most recent FASP, the safety assessment did not reflect the 1yo SS was in foster care and the RAP did not reflect the parents' homelessness or the mother's mental health.
Legal Reference:	18 NYCRR 428.6(a)
Action:	Each family assessment and service plan must include, but is not limited to, a thorough and comprehensive assessment or reassessment and analysis of the family members' strengths, needs and problems and) immediate actions or controlling interventions, as defined in section 428.2(j) of this Part, which must be taken or have been provided.
Issue:	Timeliness of completion of FASP
Summary:	Two of the Reassessment FASPs were completed late. One was due on 2/3/21 and completed on 2/25/21, and the other was due on 8/3/21 and completed on 10/6/21.
Legal Reference:	18 NYCRR428.3(f)

Action:	ECDSS will complete, or see to the completion of FASPs by service providers when applicable, by their due dates, when ECDSS maintains a case management role.
Issue:	Failure to Complete a Plan Amendment
Summary:	The record did not reflect that a Plan Amendment FASP was completed to reflect the death of the child.
Legal Reference:	18 NYCRR 428.7
Action:	ECDSS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Preventive Services History

In January 2018, ECDSS opened a voluntary preventive services case for the SM. The SM obtained stable housing, became employed and obtained medical care for herself and the 4yo SS. The services case was closed in October 2018.

In April 2019, Niagara County Department of Social Services filed a Neglect Petition regarding the 3yo SS against the SM due to concerns for her mental health. The case was closed in August 2019, after the MA obtained Article 6 custody of the SS.

In July 2020, ECDSS filed a Neglect Petition regarding the SC against the parents due to concerns for habitual unstable housing and untreated mental health. The SC remained in the care of the parents and they were asked to participate in services. In September 2020, the SC was brought to the hospital after the SF reported he was displaying seizure like behavior. The SC was diagnosed with shaken baby syndrome and there were concerns for his weight loss. An Abuse Petition was filed and the SC was removed and placed with the MA through a 1017 Direct Placement. In July 2021, the 1yo SS was born and remanded into foster care due to derivative abuse. In August 2021, ECDSS learned the parents were exercising unsupervised visitation with the 4yo SS who was in the custody of the PGM. ECDSS filed a Derivative Abuse Petition regarding the 4yo and he remained with the PGM through a 1017 Direct Placement.

Foster Care Placement History

In July 2021, the mother gave birth to the 1yo SS. The mother's other children were not in the parents' care, and there continued to be concern for unstable housing, mental health, and the injury sustained by the subject child while in the care of the parents. The relatives caring for the mother's other children were unable to take custody of the 1yo SS, and he was placed in foster care where he remained at the time this report was written.

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:**
07/07/2020	There was not a fact finding	There was not a disposition

Respondent:	062551 Father Male 30 Year(s)
Comments:	In July 2020, ECDSS filed a Neglect Petition regarding the subject child against the parents regarding ongoing unstable housing and concerns for the mother's mental health. In addition, the 4 and 3-year-old siblings were not in the parents' care. In September 2020, the child was hospitalized due to shaken baby syndrome and ECDSS filed an Abuse Petition against the parents and the child was directly placed with the maternal aunt through a 1017 Direct Placement. In July 2021, ECDSS filed a Derivative Abuse Petition against the parents upon the birth of the 1-year-old sibling and he was placed in foster care. In August 2021, ECDSS learned the parents resumed unsupervised visits with the 4-year-old sibling, who was in Article 6 custody of the paternal grandmother. Due to the pending Abuse Petition regarding the child, ECDSS filed a Derivative Abuse Petition regarding the 4-year-old sibling. The 4-year-old remained in the care of the paternal grandmother through a 1017 Direct Placement.

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
07/07/2020	There was not a fact finding	There was not a disposition
Respondent:	062548 Mother Female 23 Year(s)	
Comments:	In July 2020, ECDSS filed a Neglect Petition regarding the subject child against the parents regarding ongoing unstable housing and concerns for the mother's mental health. In addition, the 4 and 3-year-old siblings were not in the parents' care. In September 2020, the child was hospitalized due to shaken baby syndrome and ECDSS filed an Abuse Petition against the parents and the child was directly placed with the maternal aunt through a 1017 Direct Placement. In July 2021, ECDSS filed a Derivative Abuse Petition against the parents upon the birth of the 1-year-old sibling and he was placed in foster care. In August 2021, ECDSS learned the parents resumed unsupervised visits with the 4-year-old sibling, who was in Article 6 custody of the paternal grandmother. Due to the pending Abuse Petition regarding the child, ECDSS filed a Derivative Abuse Petition regarding the 4-year-old sibling. The 4-year-old remained in the care of the paternal grandmother through a 1017 Direct Placement.	

Have any Orders of Protection been issued? Yes	
From: 07/07/2020	**To:** Unknown
Explain: As a result of the petitions filed by ECDSS, the parents were required to have supervised visits.	

Additional Local District Comments

After a close review of the CPS investigations conducted during the 3 years preceding the fatality, ECDSS must unfortunately concur with the citations noted regarding the SCR reports dated 6/13/22, 9/14/20 and 9/13/20. These compliance issues are being addressed with the respective supervisors and the assigned caseworkers who remain with ECDSS. ECDSS must also concur with the compliance issues related to the preventive services history, and those citations have also been addressed with the relevant unit supervisor and case manager. While ECDSS does not have a dedicated CPS Monitoring Unit, the originating CPS unit and any CPS administrator are always available to provide guidance on issues of a child protective nature throughout the life of the services case. Additionally, current ECDSS policy is that any services case that originated with indicated CPS involvement is reviewed and approved by a CPS administrator when the services team is requesting that services are ended and case involvement is terminated. Finally, all of the identified

required actions on ECDSS cases are currently being reviewed and addressed through a consolidated PIP with the assistance of the BRO of OCFS.

WCDSS appreciates the opportunity given to us to review the report. We find that the facts describe the events and the actions taken in response. After a close review of the concerns identified during the WCDSS CPS investigation we concur with the citations listed. We acknowledge that the father did not receive a notification of the report, a follow up note was not entered regarding the safety concern identified during a home visit, and grief counseling was not offered to the 11yo cousin. These compliance issues are being addressed with the respective supervisor and caseworker. WCDSS will assure notification letters go to subjects or parents, will prioritize assessing safety and risk and ensure documentation, and will ensure necessary services are offered to all involved in the investigation.

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