Child Fatality Report

Report Identification Number: BU-23-021

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

Issue Date: Dec 20, 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: 5 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 06/28/2023
Initial Date OCFS Notified: 06/30/2023

Presenting Information

Three SCR reports were received that alleged on 6/26/23 between 6:00PM and 7:00PM, the mother, father, and adult sibling failed to supervise the 5-year-old female subject child for an unknown period of time. The child was able to exit the home, enter a swimming pool in the community and drowned. An unknown adult found the child floating in the pool. The child was unresponsive, and the unknown adult began CPR, while another unknown person called 911. First responders arrived, began resuscitative measures, and transported the child to the hospital. The child's brain had been without oxygen for approximately 45 minutes. As of 6/27/23, the child remained on a ventilator, had no brain activity, and was unresponsive to stimuli. Two brain death tests were performed on the child, which confirmed the child no brain activity. The child was pronounced deceased on 6/28/23 at 4:20PM.

Executive Summary

This fatality report concerns the death of a 5-year-old female subject child that occurred on 6/28/23. At the time of the fatal incident the family had an open CPS investigation dated 6/5/23, for concerns surrounding inadequate supervision regarding the subject child and 4-year-old sibling. Three subsequent SCR reports were made which alleged the subject child was not adequately supervised by the mother, father, or the adult sibling; the subject child left the home undetected and drowned in the neighbor's above ground pool. The SCR reports contained allegations of Internal Injuries, Inadequate Guardianship, Lack of Supervision and DOA/Fatality against the mother, Lack of Supervision, and Inadequate Guardianship against the father, and Internal Injuries, Inadequate Guardianship, Lack of Supervision against the adult sibling regarding the subject child. The four surviving siblings, ages 13, 10, and 4-years-old and 9-months-old, were assessed safe in the care of the parents.

Erie County Department of Social Services (ECDSS) learned of the drowning and immediately began gathering information regarding the incident. It was determined the day of the fatal incident the father had gone to work, and the children were home with the mother and the adult sibling. The subject child and the 4-year-old sibling had been in the garage playing on their electronics while the mother made dinner. The adult sibling and the 10-year-old sibling periodically checked on the children before dinner. At an unknown time, the subject child and 4-year-old sibling exited the residence without supervision. The mother noticed the subject child and 4-year-old sibling were not in the home. The mother and adult sibling went outside to look for the children. The 4-year-old sibling was found in the yard, and then heard a neighbor yelling there was a baby in the pool. The subject child made her way to a neighbor's above ground pool. A neighbor observed the subject child at the bottom of the pool from a window, then went outside to the pool and pulled the subject child from the pool. The neighbor began resuscitative measures while another adult called 911. First responders arrived at the home and took over resuscitative measures and transported the subject child to the hospital. Upon arrival hospital staff took over life-saving measures, and the subject child regained a pulse. The child was placed on a ventilator and transferred to another hospital for a higher level of care. Hospital staff performed two brain death tests on the subject child that confirmed the child had no brain activity. The subject child was pronounced deceased at the hospital on 6/28/23 at 4:20PM.

An autopsy was not completed due to the family's religious objection, ECDSS was in receipt of a Report of Examination from the medical examiner's office. The manner of death was accident, and the cause of death was anoxic-ischemic encephalopathy due to drowning. Law enforcement investigated the subject child's death and determined there was no criminality regarding the death. Law Enforcement closed the criminal investigation.

The siblings were seen and interviewed prior to the death. The 13 and 10-year-old siblings confirmed the subject child and the 4-year-old siblings had exited the home, on more than one occasion, and would walk to the park or go to the neighbor's home and play with the neighbor's children.

ECDSS substantiated the allegations of Internal Injuries, Inadequate Guardianship, Lack of Supervision, and DOA/Fatality against the mother regarding the subject child. ECDSS unsubstantiated the allegations of Lack of Supervision and Inadequate Guardianship against the father regarding the subject child. ECDSS inappropriately unsubstantiated the allegation of Inadequate Guardianship against the father regarding the subject child, citing the father was at work when the subject child drowned. An investigation was opened on 6/5/23 and ran concurrently with the fatality investigation. It was learned during the 6/5/23 investigation that the subject child and 4-year-old sibling were able to leave the home without any adult knowing. Although the father denied the children were able to exit the home, the older siblings corroborated that the subject child and 4-year-old sibling exited the home and went to the park nearby. The neighbor also confirmed seeing the children outside alone unsupervised. Prior to the fatality, ECDSS made the father aware that the subject child required a higher level of supervision. The record did not reflect whether a plan was made with the family on how to provide increased supervision while the father was at work. On 6/28/23, the subject child was again able to exit the home, that ultimately placed the subject child at imminent risk of harm and subsequently led to her death.

The allegations of Internal Injuries, Inadequate Guardianship, and Lack of Supervision against the adult sibling regarding the subject child were unsubstantiated; ECDSS stated the adult sibling was not a person legally responsible for the subject child.

The Risk Assessment Profile was completed inaccurately. The parents were aware the subject child and the sibling were exiting the home prior to the death, and required a higher level of supervision; therefore, the parents did not understand the seriousness or potential harm to the children and failed to address the concerns. There was a camera outside the home; however, the record reflected the father was the only person that had access to the camera. The record did not reflect the parents made provisions to stop the SC from leaving the home. The subject child exited the home which ultimately led to her demise. ECDSS missed opportunities to gather more information from collateral contacts regarding the subject child's death. The record did not reflect that ECDSS attempted to interview the neighbor that owned the pool or observe the pool the subject child drowned in.

ECDSS offered the family bereavement services, and they declined. The record did not reflect the parents were offered burial assistance. ECDSS made an Early Intervention referral regarding the sibling. In addition, ECDSS referred the family to community-based resources. At the close of the investigation the neighbor had taken down the pool and the father placed a fence around the yard. The fatality investigation was indicated and closed on 8/25/23.

PIP Requirement

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

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**

- **Approved Initial Safety Assessment?** No
- **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?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
ECDSS made an appropriate determination to indicate the investigation based on the evidence obtained throughout the investigation; however, ECDSS failed to take into consideration information in the case record to determine the allegations of Inadequate Guardianship and Lack of Supervision against the father and Internal Injuries against the mother.

Was the decision to close the case appropriate? Yes

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:
Casework activity was not commensurate with the case circumstance the Internal Injuries allegation was incorrectly substantiated against the mother. The Inadequate Guardianship allegation was incorrectly unsubstantiated against the father. The Risk Assessment Profile was completed inaccurately and ECDSS missed opportunities to gather more information from collateral contacts.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigations
Summary:	The investigation conclusion narrative did not consider, weigh, and evaluate all the information gathered and documented in the case record. Each allegation in the report was not individually addressed in the case record or in the investigation determination. ECDSS missed opportunities to gather more information form collateral contacts and the RAP was completed inaccurately.
Legal Reference:	SSL 424.6 and 18 NYCRR 432.2(b)(3)
Action:	ECDSS will refer to the CPS Program Manual and/or consult with the Buffalo Regional Office when determining the appropriateness of allegations and will take into consideration all information when applying the circumstances to the definition(s). ECDSS will review and adhere to regulations regarding casework practice in general. ECDSS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/28/2023 **Time of Death:** 04:20 PM

Date of fatal incident, if different than date of death: 06/26/2023
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: 07:48 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

- ☐ 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	Adult Sibling	Alleged Perpetrator	Male	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Month(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)

LDSS Response

Upon receipt of the SCR report on 6/27/23, ECDSS initiated their investigation, spoke with law enforcement, notified the district attorney's office, interviewed parents and collaterals, completed a home visit, and offered the parents bereavement services for the family. The record did not reflect burial assistance was offered to the family.

ECDSS interviewed the parents and learned the father was at work at the time of the fatal incident. The father had kept his

phone in a locked locker at work; however, called the mother during his breaks to check in. On 6/26/23, around 5:00PM, the father called the mother's phone, and there was no answer. The father went on break around 8:30PM and went to call the mother when he noticed he had 10 missed calls from the mother. The father said he checked the camera near the front door and noticed the SC was outside around 7:26PM, and the mother went outside around 7:32PM. The father said the adult sibling went outside at 7:36PM, and then a police officer passed by. The father called the adult sibling to see what was going on. The adult sibling told the father that the SC drowned in the neighbor's pool, and they were at the hospital. The mother reported she was cooking dinner and was unaware the SC and the 4yo SS left the home. When dinner was ready, the mother noticed the 4yo SS was in the yard and everyone went outside to look for the SC. The mother asked where the SC was and the 4yo SS pointed to the neighbor's home. The mother reported heading towards the neighbor's home and heard the neighbor yell there was a baby in the pool. Both parents denied the adult sibling regularly watched the children or that he was ever physical with them.

ECDSS spoke with the adult sibling and learned prior to dinner he checked on the SC and 4yo SS, they were in the garage playing on their electronics, and he went to his room. The mother made dinner and asked where the SC was and the adult sibling went and checked the park near the home, and the SC was not there. On his way back to the home he heard the neighbors yelling there was a baby in the pool, and he went to the neighbor's yard. The adult sibling denied the children were left unsupervised; however, the SC had left the home without an adult knowing in the past.

ECDSS spoke with the older SSs and observed the 4yo and 9-month-old SSs. The 13yo SS reported she was in her room all day and had no information regarding the SC's death. The younger siblings played outside during the day and went in the home when the mother was making dinner. The 10yo sibling checked on the SC and 4yo SS before dinner and they were in the garage playing on their electronics. The mother put dinner on the table and noticed the 4yo SS and SC were not there, and everyone went to go look for them. The 4yo SS was found in the yard and she pointed toward the neighbor's home when asked where the SC was. The 10yo SS saw the neighbors pull the SC out of the pool and the neighbor's daughter began CPR on the SC, and the SC went in the ambulance to the hospital. The 13yo and 10yo SSs reported the SC and 4yo SS had left the home before without anyone knowing and denied the adult sibling hitting them. ECDSS attempted to interview the 4yo SS; however, she was shy and would not respond to the caseworker. The 9-month-old SS was observed and unable to be interviewed based on her age. ECDSS had no concerns for the siblings or the condition of the home. Safe sleep recommendations were reviewed with the parents regarding the 9-month-old SS.

ECDSS spoke with collaterals contacts that included, first responders, hospital staff, school staff, neighbors, and the pediatrician. Neighbors observed the SC and 4yo SS previously exit the home, crossed a street, and went to a park unsupervised. The siblings were seen medically after the SC's death, and there were no concerns for their well-being. Safe sleep environments were observed for the children and safe sleep guidelines were reviewed with the parents regarding the 9-month-old SS.

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 referred to an OCFS approved Child Fatality Review Team? Yes
Comments: The fatality was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065581 - Deceased Child, Female, 5 Year(s)	065582 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
065581 - Deceased Child, Female, 5 Year(s)	065582 - Mother, Female, 33 Year(s)	Internal Injuries	Substantiated
065581 - Deceased Child, Female, 5 Year(s)	065584 - Adult Sibling, Male, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
065581 - Deceased Child, Female, 5 Year(s)	065582 - Mother, Female, 33 Year(s)	Lack of Supervision	Substantiated
065581 - Deceased Child, Female, 5 Year(s)	065582 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
065581 - Deceased Child, Female, 5 Year(s)	065583 - Father, Male, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
065581 - Deceased Child, Female, 5 Year(s)	065583 - Father, Male, 35 Year(s)	Lack of Supervision	Unsubstantiated
065581 - Deceased Child, Female, 5 Year(s)	065584 - Adult Sibling, Male, 18 Year(s)	Internal Injuries	Unsubstantiated
065581 - Deceased Child, Female, 5 Year(s)	065584 - Adult Sibling, Male, 18 Year(s)	Lack of Supervision	Unsubstantiated

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?	☐	☐	☒	☐
Explain: At the time of death, the siblings were reportedly with relatives out of state and the family declined to provide ECDSS with locating information for the siblings to be assessed. The siblings were seen at the home on 7/11/23.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: The record did not reflect the family was offered burial assistance. The Risk Assessment Profile did not accurately reflect the parents did not understand the seriousness or potential harm to the children being unsupervised, and the parents failed to address the concerns.				

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?	☐	☒	☐	☐
Explain as necessary: There was no removal regarding the surviving siblings.				

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:
The record did not reflect burial assistance was offered to the parents. ECDSS offered bereavement services to the parents on behalf of themselves and the SSs, and they declined. The record reflected an Early Intervention referral was made; however, it was unknown if the family accepted services.

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:
ECDSS offered the parents bereavement services on behalf of the children, and they declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
ECDSS offered the parents bereavement services, and they declined. The record did not reflect ECDSS offered the parents burial assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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)
06/06/2023	Deceased Child, Female, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Female, 5 Years	Mother, Female, 33 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 13 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 13 Years	Mother, Female, 33 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 10 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 10 Years	Mother, Female, 33 Years	Lack of Supervision	Substantiated	
	Sibling, Female, 3 Years	Mother, Female, 33 Years	Inadequate Guardianship	Substantiated	
	Sibling, Female, 3 Years	Mother, Female, 33 Years	Lack of Supervision	Substantiated	
	Deceased Child, Female, 5 Years	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 5 Years	Father, Male, 35 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Female, 13 Years	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 13 Years	Father, Male, 35 Years	Lack of Supervision	Unsubstantiated	

Sibling, Female, 10 Years	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 10 Years	Father, Male, 35 Years	Lack of Supervision	Unsubstantiated
Sibling, Female, 3 Years	Father, Male, 35 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 3 Years	Father, Male, 35 Years	Lack of Supervision	Unsubstantiated

Report Summary:
An SCR report alleged the SC and SSs were frequently outside alone playing without any adult supervision. The older SSs were not adequate caretakers for the younger children. The younger children were often playing and crossing the roadway without supervision and often ran into the neighbor's yards without permission. On 6/5/23, the adult sibling was dragging one of the younger children down the road by her hair while hitting her. It was unknown why the older child was doing this or if injury was caused to the younger child. The mother and father failed to provide adequate supervision of the children.

Report Determination: Indicated | **Date of Determination:** 08/29/2023

Basis for Determination:
The allegations of LS and IG were substantiated against the SM regarding the SC and the then 13, 10, and 3-year-old SSs. The investigation revealed the SM was changing the 8-month-old SS's diaper and noticed the younger children running down the street. The SM sent the adult sibling to get the children and bring them back to the home. On 6/27/23, a subsequent report was made regarding the 5yo SC drowning in a pool after the SC was able to exit the home. The allegations of LS and IG were unsubstantiated against the father, ECDSS determined the father was at work when the children were getting out of the home.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The 7-day Safety Assessment was completed timely. Written notice was provided timely. A home visit was made, and safe sleep recommendations were reviewed. A CPS history check was not completed. The record reflected the SC and 3yo SS were seen; however, the record did not reflect ECDSS attempted to interview the children.

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

Issue:
Review of CPS History

Summary:
The record did not reflect ECDSS completed a CPS history check regarding the family.

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.

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

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

Known CPS History Outside of NYS

There was no known CPS 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 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 must unfortunately concur with the citation identified by the reviewer relative to the fatality investigation. As a corrective action, since the identified compliance issues are all related to the fatality investigation, the concerns have been addressed with the supervising Team Leader and the assigned Caseworker, to include a conversation about the Risk Assessment Profile, collateral contacts, the appropriate determination of the Inadequate Guardianship allegation with respect to the father, and the instruction to reference the CPS Manual and to consult, as needed, with the OCFS Buffalo Regional Office when determining the appropriateness of allegations. We also note that the required actions related to the citation continue to be part of a consolidated Program Improvement Plan (PIP) currently being reviewed and addressed with the assistance and support of the OCFS Buffalo Regional Office.

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