Report Identification Number: BU-23-022

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

Issue Date: Dec 21, 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 | **Jurisdiction:** Erie | **Date of Death:** 06/28/2023
Age: 8 day(s) | **Gender:** Male | **Initial Date OCFS Notified:** 06/30/2023

Presenting Information

Erie County Department of Social Services (ECDSS) was notified by the father, that the 8-day-old male subject child died at the hospital. The subject child was born premature and developed a medical condition. The child remained hospitalized in the Neonatal Intensive Care Unit (NICU) since birth. The child passed away on 6/28/23. ECDSS completed a 7065 Agency Reporting Form and notified the Buffalo Regional Office on 6/29/23.

Executive Summary

This fatality report concerns the death of the 8-day-old male subject child that occurred on 6/28/23. The child died at the hospital in the NICU, where he remained since birth. At the time of the child's death, there was a 5 and 1-year-old sibling that resided in the home with the parents and a 15-year-old half-sibling that was visiting with the paternal grandfather. ECDSS assessed the siblings as safe with the parents and the grandfather.

Upon learning of the death, ECDSS gathered information from the parents and collateral contacts. ECDSS learned the child was born premature at 34 weeks, in respiratory distress. The child was intubated in the delivery room and admitted to the NICU. The child remained intubated due to an enterovirus infection. The child's condition worsened, and the infection spread to the child's lungs, and he developed a pulmonary hemorrhage. The parents were at bedside with the child during resuscitative efforts for the pulmonary hemorrhage. The parents spoke with hospital staff regarding the child's medical condition. Due to the enterovirus sepsis with multi-organ failure and clinical course with pulmonary hemorrhage, the parents made the decision to hold the child and withdraw life support. The child died at the hospital on 6/28/23 at 1:33AM.

An autopsy was not performed at the request of the parents. Due to the nature and the circumstances of the child's death law enforcement was not contacted.

At the time of the fatality, ECDSS had an ongoing open CPS investigation regarding the 15-year-old sibling. An SCR report was not made by ECDSS at the time of the child's death due to the child being hospitalized since birth and the death was not the result of suspected abuse or maltreatment by the parents.

ECDSS conducted a home visit on 7/1/23, to the paternal grandfather's home and assessed the safety of the 15-year-old sibling. There were no concerns for the sibling, and she appeared free of any marks or bruises. ECDSS made a home visit on 7/1/23 and observed the 5 and 1-year-old siblings in the care of the parents. The siblings appeared well cared for and were free of any marks or bruises. The home was found to be appropriate and there were no safety hazards.

ECDSS offered the grandfather services, and he declined. ECDSS offered the parents bereavement services, and they declined. The record reflected ECDSS provided the family with a grief packet; however, the record did not reflect ECDSS offered the family burial assistance. ECDSS closed the open CPS investigation on 7/10/23.

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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
It was determined the child's death was not the result of maltreatment by the parents, therefore there was no SCR report regarding the fatality and the completion of safety assessment tools was not required.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ECDSS gathered information regarding the death and documented supervisory conferences.

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: 06/28/2023 **Time of Death:** 01:33 AM

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

County where fatality incident occurred: Erie

Was 911 or local emergency number called? No

Did EMS respond to the scene? No

At time of incident leading to death, had child used and/or ingested alcohol or drugs? No

Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant

☐ Playing ☐ Eating ☐ Unknown
☒ Other: Hospitalized

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	No Role	Male	8 Day(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Mother	No Role	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	15 Year(s)

LDSS Response

ECDSS was notified of the death of the SC on 6/28/23. ECDSS had an open CPS investigation with the family prior to the SC's birth. The open CPS investigation was regarding the 15yo SS's behaviors. Upon notice of the death ECDSS completed the required 7065 Agency Reporting Form timely, spoke with the parents, made a home visit, spoke with collaterals, and assessed the safety of the siblings.

ECDSS received the discharge summary regarding the SC's death. ECDSS spoke with the father and learned the SC was born prematurely at 34 weeks. The SC was admitted to the NICU after birth and a few days later developed an infection. The parents were with the SC at the hospital when his medical condition worsened, and the SC had to be resuscitated. The parents decided to take the SC off the ventilator and the SC died while the parents were holding him.

There was no autopsy performed at the request of the parents. The mother refused to speak with ECDSS regarding the SC's death.

ECDSS saw and interviewed the 15yo SS and paternal grandfather at the grandfather's home on 7/1/23. The 15yo SS was observed to have no visible marks or bruises and was assessed safe with the paternal grandfather. ECDSS conducted a home visit on 7/1/23 and observed the 5 and 1-year-old siblings. The SSs had no visible marks or bruises and were assessed safe with the parents. The pediatrician was contacted regarding the SSs and there were no concerns.

ECDSS offered the parents bereavement services, and they declined. ECDSS provided the father with a list of community-based resources and a grief package. ECDSS offered the paternal grandfather bereavement services, and he declined.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

Comments: ECDSS has an OCFS approved Child Fatality Review Team; however, neither the 7065 nor the open CPS investigation reflected if the fatality would be referred to it for review.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

ECDSS contacted appropriate collaterals and investigated the circumstances surrounding the child's death. The child was hospitalized for the duration of his life.

Fatality Safety Assessment Activities

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

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
There was no SCR report surrounding the fatality, therefore, the completion of the risk assessment was not required.

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:
The fatality was not SCR reported; therefore, certain casework activity was not required

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:
ECDSS offered the family bereavement services, and they declined. The record did not reflect the family was offered burial assistance.

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 family 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 the family was offered burial assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Had heavy alcohol use
☐ Smoked tobacco
☐ Used illicit drugs
☐ Used prescription drugs

☐ Used marijuana
☒ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology
☐ With fetal alcohol effects or syndrome
☐ Exhibiting withdrawal symptoms
☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/23/2023	Sibling, Female, 15 Years	Mother, Female, 30 Years	Choking / Twisting / Shaking	Unsubstantiated	No
	Sibling, Female, 15 Years	Mother, Female, 30 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 15 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 15 Years	Father, Male, 34 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 15 Years	Father, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged, the father got angry with the 15yo SS for having an attitude and made her do jumping jacks for 10 minutes as a form of punishment. The 15yo SS had to stop and lay down because her legs were hurting and burning. The father helped the 15yo SS off the floor and hit her in the face twice. As a result, the 15yo SS had pain to her ear for 5 minutes but did not sustain any visible injuries. The mother overheard what was going on while she was in another room. The mother went into the room where the father and 15yo SS were and choked the 15yo SS as she pushed her onto the couch. As a result, the 15yo SS had trouble breathing. The role of the 5 and 1yo SSs was unknown.

Report Determination: Unfounded
Date of Determination: 07/10/2023

Basis for Determination:
ECDSS unfounded the allegations of IG and XCP against father and mother regarding the 15yo SS, and the allegation of C/T/S against the mother regarding 15yo SS due to a lack of a fair preponderance of evidence. The parents denied the allegations and the 15yo SS had no visible marks or bruises. The parents expressed concerns regarding the 15yo SSs behaviors that presented as a safety concern for the 5 and 1yo SSs. The 15yo SS was referred for respite and community-based services. The 15yo SS went to respite and was discharged from respite due to her disrespectful behaviors. The SC was born during the open case. The 15yo SS was residing with the PGF at the close of the CPS investigation.

OCFS Review Results:
ECDSS began the investigation within 24 hours, contacted the source, completed a history check, made a home visit, and interviewed the family members in the home. ECDSS spoke with collateral contacts; however, ECDSS missed the opportunity to follow up with law enforcement regarding the family.

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)
03/31/2022	Sibling, Female, 5 Years	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
An SCR report alleged that while the 5yo SS was taking a bath, the father walked into the bathroom and urinated into the bathwater.

Report Determination: Unfounded | **Date of Determination:** 05/11/2022

Basis for Determination:
ECDSS unfounded the allegations of IG against the BF regarding the 5yo SS due to a lack of a fair preponderance of evidence. The family was seen and interviewed. The father, mother, 15yo SS and the 5yo SS denied the allegations in the report. Collateral contacts were made and there were no concerns for the family.

OCFS Review Results:
ECDSS began the investigation within 24 hours. ECDSS contacted the source, completed a history check, made a home visit, and interviewed family members. ECDSS reviewed safe sleep guidelines with both parents. ECDSS contacted collateral sources and there were no concerns for the family.

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)
12/11/2021	Sibling, Male, 2 Days	Mother, Female, 28 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 2 Days	Mother, Female, 28 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged on 12/9/21, the mother tested positive for THC after giving birth to the now 1yo SS. The mother admitted to using THC. The now 1yo SS was not tested and there were no other concerns at that time. The father had an unknown role.

Report Determination: Unfounded | **Date of Determination:** 02/10/2022

Basis for Determination:
ECDSS unfounded the allegations of IG and PD/AM due to lack of credible evidence. The now 1yo SS was not tested at birth for drugs and did not display any signs of withdrawal. ECDSS spoke with the mother's mental health counselors, and there were no concerns for the mother's marijuana use or her ability to care for the children. ECDSS did not observe any alcohol, drugs, or drug paraphernalia, in the home during the investigation. The adults appeared sober and coherent during home visits.

OCFS Review Results:
ECDSS began the investigation within 24 hours. ECDSS contacted the source, completed a history check, and engaged with all the family members in the home. ECDSS went over safe sleep guidelines and completed a plan of safe care with the parents. ECDSS spoke with collateral contacts. The now 15yo SS was overdue for a well visit at the doctors with no appointment scheduled; however, the record did not reflect ECDSS addressed this with the parents. ECDSS inaccurately completed safety assessments and the risk assessment profile.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)

Summary:
The RAP was scored that the mother's drug use had negative effects on childcare, family relationships, jobs, or arrests, within the past 2 years; however, the record did not reflect the mother's marijuana use negatively affected the family. ECDSS made home visits and followed up with collaterals regarding the mother and there were no concerns.

Legal Reference:
18 NYCRR 432.2(d)

Action:

ECDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The investigation determination safety assessment reflected the same safety concerns as the 7-day safety assessment; however, the record did not reflect there was a negative impact on the siblings as a result of the mother's marijuana use. The investigation conclusion reflected ECDSS met with the mother multiple times, and she appeared sober and coherent, and had no concerns for the family.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/13/2021	Sibling, Female, 13 Years	Mother, Female, 28 Years	Inadequate Guardianship	Substantiated	Yes
	Sibling, Female, 13 Years	Father, Male, 33 Years	Lack of Medical Care	Substantiated	

Report Summary:

An SCR report alleged on an unknown date the mother pushed the now 15yo SS against a wall and made her run up and down the stairs of the home for disobeying her. On a regular basis, the mother made negative statements and talked down to the SS to the point where the SS was upset and distraught. The role of the father and the now 5yo SS was unknown.

Report Determination: Indicated | **Date of Determination:** 11/19/2021

Basis for Determination:

The allegation of IG against the mother and the allegation of LMC against the father regarding the now 15yo SS were substantiated. The investigation revealed the mother made the SS run the stairs with a broken nose as punishment which appeared to be excessive, because the SS had difficulty breathing due to the broken nose. ECDSS added the allegation of LMC against the father. ECDSS determined the SS displayed behaviors prior to CPS intervention that may have been assisted through counseling services; however, the father did not link the SS with services.

OCFS Review Results:

ECDSS began the investigation within 24 hours. ECDSS contacted the source, completed history checks, and engaged with all the family members in the home. ECDSS contacted law enforcement and mental health collaterals; however, the record did not reflect the pediatrician was contacted regarding the children. The investigation determination and the appropriateness of the LMC allegation were not supported by the case record.

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

Issue:

Appropriateness of allegation determination

Summary:

ECDSS added and substantiated the allegation of LMC to the report against the father regarding the sibling. The investigation conclusion narrative did not consider, weigh, and evaluate all the information gathered and documented in the case record. The LMC allegation was not individually addressed in the case record or in the investigation determination. The record was unclear what impact the parents' failure to engage the child in prior mental health services posed.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

ECDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the (whichever) Regional Office if further guidance is needed.

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The investigation determination safety assessment reflected the same safety concerns as the 7-day safety assessment; however, the investigation conclusion stated the sibling was engaged in mental health treatment and ECDSS had no concerns for the family.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There were missed opportunities to gather collateral information from the pediatrician regarding the siblings. The record reflected ECDSS obtained a release of information for the pediatrician for the siblings; however, there was no documentation in the record ECDSS made any contact with the pediatrician.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

ECDSS will make diligent efforts to contact collaterals to potentially gather outside information.

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

On 1/20/20, the mother and father were named subjects in an indicated investigation with allegations of IG and LS regarding the now 15yo SS. A voluntary preventive services case was opened for the family.

On 11/7/19, the mother and father were named subjects in an unfounded investigation with allegations of IG and IF/C/S regarding the now 15yo SS.

On 2/15/19, the father was a named subject in an unfounded investigation with allegations of IG and EdN regarding the now 15yo SS.

On 5/6/15 and 8/3/15, the father was a named subject in an unfounded investigation with allegations of IG and LS regarding the now 15yo SS.

On 11/4/14, the father was a named subject in an indicated investigation with allegations of XCP, IG, and L/B/W regarding the now 15yo SS.

On 3/24/14, the father was a named subject on an indicated investigation with allegations of IG and LS regarding the now 15yo SS.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

ECDSS opened a voluntary preventive services case from 1/29/20-11/12/20. There were concerns for the parents being unable to control the now 15yo SS's behaviors and the parents were withholding food as a form of punishment. There were concerns the SS was climbing out of her bedroom window and going to neighbor's homes complaining she was hungry and had been without food. The mother was making negative comments to the SS about being bad and that the SS would have to go live somewhere else, which upset the SS. The preventive services case was closed on 11/12/20. The parents completed a parenting program and learned appropriate ways to discipline and deal with the SS's behaviors. The SS engaged and participated in mental health counseling, her behaviors improved, and she was taking her medication as prescribed. At the close of the preventive services case there were no concerns for the family and the parents appeared to be addressing the SS's behaviors appropriately.

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 (ECDSS) appreciate the opportunity given us to review the draft fatality report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. With regard to the CPS investigations conducted during the three years preceding the fatality, we unfortunately must concur that the identified compliance issues regarding the SCR report dated October 13, 2021 are accurate relative to the appropriateness of the added allegation determination and the documentation of safety assessments. Relative to the issue of collateral contacts, although we concur that a collateral contact with the siblings' pediatricians could have been more vigorously pursued, we would like to point out that a progress note dated October 13, 2021 entered by the Team Leader does reflect a conference with a Children's Services Case Manager stating that the siblings had been recently seen by their respective pediatricians and were up to date at that time. With respect to the SCR report dated December 11, 2021, we must unfortunately agree with the identified compliance issues relative to the adequacy of the Risk Assessment Profile (RAP) and the documentation of safety assessments. We concur that the identified RAP score and the safety assessment failed to adequately reflect the actual documented case circumstances. We note that the required actions related to the above citations 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. As a supplement, ECDSS will review the citations specific to this report with the respective workers and their supervisors, and in their absence, with those workers' supervisory chain. Additionally, we will consult the CPS Program Manual as well as the OCFS Buffalo Regional Office when further guidance is needed.

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