Child Fatality Report

Report Identification Number: BU-23-038

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

Issue Date: Mar 29, 2024

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: 1 month(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 10/24/2023
Initial Date OCFS Notified: 10/24/2023

Presenting Information

An SCR report alleged that on 10/23/23, the mother fell asleep while she was breastfeeding the one-month-old subject child. In the morning on 10/24/23, the mother was awoken by the 3-year-old surviving sibling. The mother found the subject child unresponsive with blood coming from her nose. The mother contacted emergency medical services and upon arrival, they administered cardiopulmonary resuscitation on the subject child, which was unsuccessful. The subject child was pronounced deceased at the scene. It was believed the unsafe sleep situation contributed to the child's death.

Executive Summary

On 10/24/23, Erie County Department of Social Services (ECDSS) received an SCR report regarding the death of the 1-month-old female child. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the subject mother. At the time of her death, the subject child resided with the subject mother and the 3-year-old surviving sibling. The children's father resided locally and often cared for the children. ECDSS immediately assessed the safety of the surviving sibling and determined she was safe in the care of the subject mother.

Through a joint investigation with law enforcement, it was learned that on 10/24/23, between 2:20-2:40AM, the mother breastfed the subject child and fell asleep while holding the child. Around 6:00AM, the 3-year-old surviving sibling woke the mother to use the bathroom. The mother was on the bed with the subject child located on the side of her. The mother moved the subject child further to the side and went into the bathroom. While in the bathroom, the SM felt wetness on her right side, she turned on the light and observed blood. The subject mother then checked on the subject child and observed blood coming from her mouth. The subject mother contacted 911 and the mother was advised how to perform cardiopulmonary resuscitation. Emergency medical services arrived and took over life-saving efforts but were unsuccessful. The subject child was pronounced deceased at the residence at 7:01AM.

ECDSS spoke with the medical examiner on 10/25/23 and learned there were no signs of abuse or trauma to the subject child. The preliminary findings showed accidental positional asphyxiation. At the time this report was written, the final autopsy report was still pending awaiting further testing.

ECDSS spoke with law enforcement and learned the criminal investigation was ongoing pending the final autopsy, though they had no plans to file criminal charges against the mother with the information known at the time ECDSS closed their investigation.

ECDSS appropriately substantiated the above referenced allegations against the subject mother regarding the subject child. The subject mother was breastfeeding the subject child and fell asleep before placing the child in a safe sleeping environment. The mother was aware of and educated about safe sleep practices at the hospital and by the subject child's pediatrician. In addition, information for the preliminary cause of death was accidental positional asphyxiation.

ECDSS provided the mother and father with information regarding bereavement and grief services. Both parents declined needing referrals. The mother utilized an independent provider for counseling services. The 3-year-old sibling was seeing a counselor that was already established prior to the fatality who offered to complete family sessions until the mother's mental health services started. The record reflected ECDSS did not offer burial assistance to the parents. ECDSS gathered pertinent information from collaterals such as the childrens' pediatricians, EMS, law enforcement, the fire department,

medical examiner, the maternal grandmother, and neighbors. The subject mother was interested in donating her leftover breast milk to families in need. ECDSS assisted the mother with obtaining information on the procedures for donating her breastmilk and she was able to assist a family within the community.

PIP Requirement
For citations identified in historical cases, 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?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

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

Explain:
ECDSS made an appropriate decision to substantiate the allegations based on evidence obtained throughout their investigation.

Was the decision to close the case appropriate? Yes

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:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/24/2023 **Time of Death:** 07:01 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? Yes
Time of Call: 06:10 AM
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	Deceased Child	Alleged Victim	Female	1 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Other Household 1	Father	No Role	Male	22 Year(s)

LDSS Response

Upon receipt of the SCR report, ECDSS initiated their investigation, contacted the source of the report, reviewed prior CPS history, coordinated their efforts with LE and notified the DA and ME. ECDSS immediately assessed the SS to be safe in the home and in the care of the SM.

ECDSS interviewed the SM at her home on 10/24/23. During her interview, she explained at 11:30PM on 10/23/24, she put the 3yo SS to bed and breastfed the SC at 11:40PM. After the feeding, the SM placed the SC in a swing while she watched the television. On 10/24/23, between 2:20 and 2:40AM, the SM reported the SC was fussy, she picked up the SC and bassinet and brought them into her bedroom. The SM then breastfed the SC and fell asleep. Between 5 and 6:00AM, the 3yo SS woke to use the bathroom and the SM woke up with her. The SM explained the SC was laying to the right side of the SM, and she moved her further to the side so she could help the SS in the bathroom. While in the bathroom, the SM felt a wetness on her right side, she turned on the light and noticed it was blood. She immediately checked on the SC and

observed blood coming from her mouth. At first, the SM was unable to find her cell phone, the 3yo SS found the phone and then the SM contacted 911. The 911 operator advised the SM to check the SCs pulse and then explained how to perform CPR. The SM laid the SC flat on the floor and described her as being warm. The SM attempted CPR, shortly after EMS arrived and took over life-saving efforts for 30 to 40 minutes but were unsuccessful. The SC was pronounced deceased at the home at 7:01AM.

ECDSS interviewed the BF at his residence on 10/31/23. During his interview, he explained at the time of the incident he was working. The BF received a phone call from the MGM asking him if he could find coverage for his work shift as the SC was deceased. The BF arrived at the home and explained the 3yo SS was not in the home and was being cared for by a neighbor. The BF reported the SM told him the SC was fine the evening prior and in the early morning. The SM explained to him that she breastfed the SC and woke up to the child deceased. The BF denied any concerns for the mother or her parenting abilities.

ECDSS interviewed the neighbor who assisted the family during the incident. During her interview, the neighbor recalled being asleep in her home and waking to screaming between 6-6:30AM. The neighbor then saw and heard EMS and LE arrive at the home and the SM screaming “we're back here.” The neighbor then went to the SM’s apartment and observed her and the SC on the floor with the first responders and asked the SM if she wanted her to take the 3yo SS. The SM requested the neighbor take the SS, she found her in her bedroom and told the SS to close her eyes and took the SS to her apartment. While in the SM’s apartment, she heard the SM tell EMS she was breastfeeding the SC and fell asleep and woke to the SC being non-responsive. The neighbor then contacted the MGM who arrived shortly after the phone call. The neighbor denied having any concerns for the SM or BF.

ECDSS communicated with the subject child’s pediatrician and learned the SC was seen regularly. The SC was born at 34 weeks gestation via c-section and was admitted to the hospital after her birth for monitoring, until her discharge on 9/28/23. The SC was seen at the practice on 9/30/23, 10/2/23, 10/5/23, 10/12/23, and lastly the day prior to the fatality on 10/23/23. The SC was consistently gaining weight at each appointment and there were no concerns noted at any of the visits.

ECDSS communicated with the 3yo SSs pediatrician and learned the SS was medically evaluated on 10/25/23. There were no signs of abuse or physical trauma to the SS and no other concerns were noted regarding her physical health.

ECDSS communicated with EMS, the fire department and LE who responded to the scene. All responders reported the mother appeared sober and there were no additional concerns noted

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? Yes
Comments: Erie County referred this case to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066592 - Deceased Child, Female, 1 Month(s)	066593 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
066592 - Deceased Child, Female, 1 Month(s)	066593 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☒	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

ECDSS attempted to interview the 3yo SS but due to her age and development were unable to complete the interview.

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:
ECDSS offered appropriate needed services during their investigation; however, the mother was utilizing her own resources for any family needs.

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.

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? Yes
Explain:
The mother and father were provided information regarding bereavement and grief services. The 3-year-old sibling was seeing a counselor that was already established prior to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother and father were provided information regarding bereavement and grief services. Both parents declined referrals. The mother was scheduled to participate with her own provider; however, sessions had not yet started at the time of case closure. The 3yo SS's therapist agreed to complete family sessions until the mother was able to start her own mental health services.

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? No

Infants Under One Year Old

During pregnancy, mother:
☒ Had medical complications / infections
☐ Had heavy alcohol use
☐ Misused over-the-counter or prescription drugs
☐ Smoked tobacco

☐ Experienced domestic violence
☐ Had a positive toxicology at the time of delivery
☐ Used marijuana
☐ Used illicit drugs
☐ Used prescription drugs
☐ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology
☐ Exhibiting withdrawal symptoms
☐ With fetal alcohol effects or syndrome
☒ 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)
01/04/2021	Sibling, Female, 9 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report was received and alleged on 12/30/20, the mother attempted to hit another individual with her vehicle while the 9-month-old surviving sibling was present in the vehicle. The mother drove towards the other adult and pinned the other adult against another vehicle during the incident.

Report Determination: Unfounded **Date of Determination:** 06/17/2021

Basis for Determination:
ECDSS did not find credible evidence to support the allegations. ECDSS confirmed the mother did have a confrontation with another individual who lived in the residence, but the 9-month-old surviving sibling was not affected by the incident. ECDSS observed video footage and could not confirm the sibling was in the vehicle and they did not observe the mother hitting the individual with her vehicle. The mother moved out of the residential home and secured new housing.

OCFS Review Results:
ECDSS initiated their investigation within 24 hours and contacted the source of the report. The history review was completed 5 months after the SCR report date. There was no casework activity from 1/7/21 until 5/3/21. The record was missing documentation of a home visit as it appeared the first face-to-face contact with the SM and SS was on 1/6/21. A law enforcement referral (LER) was made and there was no follow up with law enforcement regarding the status of their investigation. Safe sleep information was not provided or discussed with the mother. The case was closed untimely and was open for 5 months.

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

Issue:
Failure to provide safe sleep education/information

Summary:
There was no documentation that ECDSS provided information regarding safe sleep or educated the mother about safe sleep practices.

Legal Reference:
13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:
ECDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The biological father was added to the report as a parent, he was not notified about the investigation and there was no effort to interview him.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
ECDSS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Review of CPS History
Summary:
A CPS history check was completed untimely. The SCR report was received on 1/4/21; however, the history check was not completed until 6/16/21.
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:
Contact/Information From Reporting/Collateral Source
Summary:
There were missed opportunities to gather collateral information from law enforcement. A law enforcement referral (LER) was made and ECDSS did not attempt to obtain information regarding the status of their investigation.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ECDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:
Adequacy of Progress Notes
Summary:
The record did not reflect an initial home visit with the mother and sibling. A case conference note and information contained in the initial safety assessment reported the mother and SS were seen; however, it was unclear what date this visit occurred and if the allegations in the report were addressed.
Legal Reference:
18 NYCRR 428.5
Action:
ECDSS will accurately document all casework activity into progress notes.

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

ECDSS received an SCR report on 8/30/20 and substantiated allegations of Inadequate Guardianship against the father regarding the 3yo SS. The investigation was closed on 11/5/20.

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 (ECDSS) appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality.

With respect to the CPS investigation conducted during the three years preceding the fatality, we must unfortunately concur with the reviewer's findings. Upon a thorough review of the SCR report dated January 4, 2021, we acknowledge the compliance issues identified by the reviewer, namely: that ECDSS failed to document the provision of safe sleep education/information; that, although the biological father was added to the report, he was not notified of the investigation and no effort was made to interview him; that the CPS history check was not completed until months into the investigation; that there was a missed opportunity to gather collateral information from law enforcement; and that, although an initial home visit with the mother and sibling was mentioned in a case conference note and in the initial safety assessment, there was no progress note documenting said home visit with the mother and sibling.

The required actions related to the above findings 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. However, as an additional corrective action, the identified compliance concerns will be reviewed and addressed directly with the investigating caseworker and relevant supervisory staff. These concerns will also be reviewed and discussed with all CPS supervisors at an upcoming Team Leader meeting.

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