Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-23-043

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

Issue Date: May 21, 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: 3 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 12/11/2023
Initial Date OCFS Notified: 12/14/2023

Presenting Information

On 12/15/23, an SCR report alleged on or about 11/25/23, the subject child (SC) was not eating and appeared lethargic. The symptoms lasted for 2 days before the mother (SM) called 911 and sought medical treatment. The SC appeared to be in cardiac arrest and was transported to the hospital, where his body temperature was 90 degrees, and he had a blood glucose level of 25. The SC started having seizures and was placed on a ventilator. On 12/10/23 and 12/11/23, the SC had two brain death tests that showed no brain activity. On 12/11/23, the SC was removed from life support and declared deceased due to bilateral herniation. The SM and father (SF) were both aware of the SC's symptoms and failed to seek medical attention in a timely manner; as a result the SC passed away.

Executive Summary

This fatality report is regarding the death of a 3-month-old male subject child that occurred on 12/11/23. Erie County Department of Social Services (ECDSS) received an SCR report on 12/15/23, with allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Medical Care against the mother and father regarding the subject child. Prior to the child's hospitalization, the child resided with his mother, father, the 3-year-old, 1-year-old, and twin 3-month-old sibling. The child was hospitalized at the time of his death, the mother went to a shelter, and the siblings stayed with the maternal grandmother. There was an open CPS investigation at the time of the death regarding the father's substance misuse to impairment in the presence of and while caring for the 3-year-old and 1-year-old siblings. ECDSS assessed the siblings as safe with the maternal grandmother in another county

ECDSS learned the child was born prematurely at 28 weeks. The mother reported on 11/25/23 and 11/26/23, the child was having difficulty breathing, had a decrease in appetite and was not acting normally. On 11/27/23, the mother had difficulty waking the child, he was cold and appeared pale in color. The mother called 911. First responders arrived at the home and the child was in cardiac arrest. First responders began resuscitative measures and transported the child to the hospital. Upon arrival at the hospital, hospital staff took over life-saving measures. The child was in extreme sepsis, with a body temperature of 88 degrees and low blood sugar level of 23. The child was placed on life support and admitted to the Neonatal Intensive Care Unit (NICU) for respiratory syncytial virus infection (RSV), sepsis with acute hypoxic respiratory failure and septic shock, subclinical status epilepticus, and severe hypoxic ischemic encephalopathy. While in the NICU, the child's medical condition continued to decline. Hospital staff reported the child underwent two brain death tests, which revealed no brain activity, and the SC was declared deceased at the hospital on 12/11/23 at 3:58pm.

ECDSS spoke with the medical examiner's office, and they were aware of the death; however, an autopsy was not completed. The parents opted for organ donation. Hospital staff reported not finding any sign of trauma or abuse to the child and the death was the result of a medical condition. Hospital staff declined to comment on if the delay in seeking medical care contributed to the child's death. The record did not reflect if law enforcement investigated the death.

ECDSS offered the mother burial assistance and bereavement services, and the mother accepted the services. The mother engaged with counseling and remained engaged with the community-based services she was receiving. ECDSS sent a referral to the domestic violence advocate for the mother. ECDSS offered the father bereavement services, and he declined the services. ECDSS unsubstantiated the allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Medical Care against the mother and father regarding the subject child. ECDSS determined the child's death was not a result of the of the parent's actions or inactions and the death was attributed to a virus. The CPS investigation was unfounded and closed on 2/20/24.

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?** 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 determination based on the evidence obtained throughout the investigation.

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:

The level of casework activity was commensurate with case circumstances. Multiple progress notes were entered more than 30 days after their event dates.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Multiple notes were entered more than a month after their event date.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or

	the receipt of the information which is to be recorded.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/11/2023 **Time of Death:** 03:58 PM

Date of fatal incident, if different than date of death: 11/27/2023
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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- ☐ 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	Male	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	52 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Month(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Other Adult - Father of the 3yo SS	No Role	Male	25 Year(s)

LDSS Response

On 12/15/23, ECDSS received a report regarding the death of the SC. ECDSS initiated their investigation within 24 hours. ECDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. ECDSS conducted an initial home visit on 12/15/23. The SSs were seen and assessed safe in the care of the MGM.

ECDSS interviewed all the adults regarding the days leading up to the SC's hospitalization and learned the SC and the twin SS shared a bassinet. On 11/22/23, the twin SS was seen medically and diagnosed with a virus. On 11/25/23, the SM reported the SC was not crying as much, interacting less, sleeping more, and he appeared to be working harder to breathe. On the morning of 11/27/23, the SM gave the SC a bottle and the SC was not looking at her or responding like he normally did, and she called 911. The SF reported he worked two jobs, and the SM was the primary caregiver of the children. The morning of 11/27/23, the SF left for work around 5:00am, and the SC was asleep. The SF reported the SC was less active than the twin SS and he did not notice the SC acting abnormally when he was home.

ECDSS engaged the verbal SSs; however, they were unable to provide addition information. ECDSS observed the SSs, who appeared free from any visible marks and bruises. The SSs received medical examinations following the death and there were no concerns. The SSs were assessed as safe and remained in the care of the maternal grandmother through an informal plan the SM made, until the SM obtained housing.

ECDSS interviewed hospital staff regarding the SC's death and learned the SC arrived at the hospital on 11/27/23, in cardiac arrest with extreme sepsis, a low temperature, and low blood sugar levels. The SC was revived, admitted and transferred to the NICU, where he remined until his death. Hospital staff reported the SC was unstable throughout his hospitalization and abuse testing was unable to be performed. While in the NICU the SC experienced seizures and neurological hyperventilation/hypoxic. Two brain death tests were performed, and the SC was pronounced deceased at the hospital on 12/11/23. The parents agreed to organ donation, and an autopsy was not completed.

ECDSS contacted collateral sources, including hospital staff, school staff, LE, the pediatrician, and the SM's community resource worker. EDCSS offered the SM bereavement services and prior to the CPS investigation closing the SM engaged with the services. ECDSS offered the SF services and he declined. ECDSS assisted the SM and MGM with food, clothing, supplies and a pack-n-play for the SSs. At the close of the investigation, the SSs were deemed as safe in the care of the MGM and the SM remained in shelter placement. ECDSS did not find any credible evidence to support the allegations in the report, unfounded the investigation, and closed the case.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Hospital physician

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
067048 - Deceased Child, Male, 3 Month(s)	067050 - Father, Male, 52 Year(s)	DOA / Fatality	Unsubstantiated
067048 - Deceased Child, Male, 3 Month(s)	067049 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated

067048 - Deceased Child, Male, 3 Month(s)	067050 - Father, Male, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
067048 - Deceased Child, Male, 3 Month(s)	067049 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
067048 - Deceased Child, Male, 3 Month(s)	067049 - Mother, Female, 24 Year(s)	Lack of Medical Care	Unsubstantiated
067048 - Deceased Child, Male, 3 Month(s)	067050 - Father, Male, 52 Year(s)	Lack of Medical Care	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☐	☒	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The record did not reflect that ECDSS spoke with first responders or law enforcement that responded to the home on the day of the fatal incident. The SC remained hospitalized after the fatal incident until his death.

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:
The mother was engaged in community-based services prior to the death of the subject child. Ongoing support was provided following the death. The father declined bereavement services.

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 SM was engaged with community-based services prior to the death of the subject child. Ongoing support was provided following the death. ECDSS offered the father bereavement services, and he declined.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
ECDSS provided the SM a list of community-based resources on behalf of the siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ECDSS offered the mother bereavement services and burial assistance, which she accepted. The mother engaged with grief counseling services prior to the case closing. ECDSS offered the father bereavement services, and he declined.

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? 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
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ 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)
11/27/2023	Deceased Child, Male, 3 Months	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 3 Months	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Months	Father, Male, 52 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 3 Months	Father, Male, 52 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 3 Years	Father, Male, 52 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Father, Male, 52 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 52 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 1 Years	Father, Male, 52 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 3 Months	Father, Male, 52 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 3 Months	Father, Male, 52 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:

An SCR report alleged the father used illegal substances to impairment in the presence of and while caring for the SSs, ages 3 and 1yo. The father was unable to provide the SSs with a minimum degree of care. The mother did not intervene to protect the SSs from being exposed to the father's substance misuse. The SC and twin SS were born premature and were exposed to the father's substance misuse since they arrived at the residence. The residence was filthy and infested with cockroaches, which posed health hazards to the children.

Report Determination: Unfounded | **Date of Determination:** 02/16/2024

Basis for Determination:
The investigation revealed the SF did not appear to be under the influence during interactions with ECDSS. A home visit was completed after the SM and SSs were no longer residing in the home and there were no safety hazards observed. The SM made a plan for the SSs to reside with the MGM in another county. ECDSS unsubstantiated the allegations of IG against the SM and the allegations of IG and PD/AM against the SF.

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. The SF would not allow ECDSS in the home and the SSs were seen in the doorway. Safe sleep recommendations were provided. A CPS history check was completed untimely. Multiple progress notes were entered more than a month after their event dates.

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

Issue:
Review of CPS History
Summary:
A CPS history check was completed untimely on 12/16/23.
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:
Timely/Adequate Case Recording/Progress Notes
Summary:
Multiple progress notes were entered more than a month after their event dates.
Legal Reference:
18 NYCRR 428.5
Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/27/2023	Sibling, Male, 3 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 23 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Sibling, Male, 1 Years	Mother, Female, 23 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Sibling, Male, 1 Years	Mother, Female, 23 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report and 2 subsequent reports alleged the home where the SM, 3yo, and 1yo SSs resided was infested with bugs including cockroaches and bed bugs. There was dog and cat urine and feces throughout the home. The mother failed to address the conditions of the home. The SM was irate and out-of-control on a daily basis. The SM was verbally and physically abusive toward the 3yo SS and he sustained marks and bruises as a result. Niagara County was assigned a secondary role.

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

Basis for Determination:
The investigation revealed the home was not in deplorable conditions and did not present with animal feces or urine. The SM was trying to take care of the bug infestation. At no time did the SM and SS reside in deplorable conditions. During the investigation, the SM and the SSs left the home, were temporarily housed in a hotel in Niagara County, and later moved in with the SF. The 3yo SS was observed throughout the investigation and had no concerning marks or bruises. There was no evidence the SM was irate, out-of-control or harming the children. ECDSS unsubstantiated the allegations of IF/C/S, IG, and L/B/W against the SM and closed the CPS investigation.

OCFS Review Results:
The investigation was initiated timely, and the sources of the reports were contacted. The 7-day Safety Assessment was completed timely. The CPS history check was completed untimely. Written notice was provided untimely. A home visit was completed on 3/28/23. The SM was seen and interviewed. Collateral contacts were made. Safe sleep recommendations were provided.

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

Issue:
Review of CPS History

Summary:
A CPS history check was completed untimely on 5/11/23.

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

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/12/2021	Sibling, Male, 1 Years	Other Adult - Father of the now 3yo SS, Male, 23 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
An SCR report alleged the SM and the BF of the SS got into a verbal dispute which escalated in the presence of the then 1yo SS. The BF aggressively forced himself into the home and hit the mother resulting in a cut to the SM's neck. The BF then left with the SS in 40-degree weather, with the SS only wearing a diaper. The SS was shaking and cold as a result. The mother had an unknown role.

Report Determination: Indicated | **Date of Determination:** 01/04/2022

Basis for Determination:

The investigation revealed there was a stay away OP in place protecting the SM and the SS from the BF. The BF went to the SM's home, forced his way into the home and assaulted the SM in front of the then 1yo SS. The BF took the SS from the home in the cold weather while he was dressed in a diaper. The BF was arrested and charged criminally. ECDSS substantiated the allegations of IG against the BF regarding the then 1yo SS. The SM and the SS remained engaged with the open Preventive Services Case.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The CPS history check was completed timely. The 7-day Safety Assessment was completed timely. Written notice was provided to the adults. Home visits were made, and the SS was assessed to be safe. Collateral contacts were made. ECDSS made diligent efforts to contact the BF.

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)
08/12/2021	Sibling, Male, 1 Years	Other Adult - Father of the now 3yo SS, Male, 23 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
An SCR report alleged the BF of the SS physically assaulted the SM in the presence of the then 1yo SS. The BF punched the SM in the head and face. There was a history of the BF assaulting the SM in the presence of the SS.

Report Determination: Indicated **Date of Determination:** 08/27/2021

Basis for Determination:
The investigation revealed the BF assaulted the SM while she was holding the SS, and she sustained swelling to her face as a result. LE records showed previous domestic incidents. The SM worked with a DV advocate and obtained a full stay away OP for herself and the SS against the BF through family court. The BF was granted supervised visitation with the SS. ECDSS substantiated the allegation of IG against the BF regarding the SS. The SM agreed to and engage in preventive services.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. The CPS history check was completed timely. The 7-day Safety Assessment was completed timely. Written notice was provided timely. Home visits were made and all adults were seen and interviewed. The SS was assessed to be safe with the SM. Collateral contacts were made. Safe sleep recommendations were provided to the SM.

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

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

In 2020, the 3yo SS was named as a maltreated child in an unfounded investigation with allegations of IG and IF/C/S against his BF.

In 2020, the 3yo SS was named as a maltreated child in an unfounded investigation with allegations of IF/C/S against the SM.

The SF had indicated history regarding his now adult children dating back to 1998, which contained allegations of IG, L/B/W, LS, and S/D/S.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

On 8/13/21, a Preventive Services Case was opened due to ongoing domestic violence in the home. The SM worked with DV services and obtained a full stay away OP, protecting the SM and the 3yo SS against the 3yo SS's father. The SM had a history of DV relationships where she was the victim. The SM took the SS and stayed with a family member at a location unknown to the SS's father. ECDSS aided the SM with family court proceedings and with help obtaining housing. The case was closed on 5/16/22. The SM completed the goals of the services case and obtained safe and stable housing.

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 reviewer's finding relative to the fatality, namely that multiple progress notes were entered more than a month after their event date. With regard to the SCR investigations conducted within the three years preceding the fatality, we must agree with the reviewer's findings relative to the SCR reports dated March 27, 2023 (for untimely review of CPS history) and November 27, 2023 (for untimely review of CPS history and untimely entry of progress notes). The required actions related to the above findings are 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 an additional corrective measure, the specific citations have been or will be discussed and addressed directly with the relevant investigating caseworkers and their supervisors.

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