NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-15-042 **Prepared by: Buffalo Regional Office**

Issue Date: 5/2/2016

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 has an open 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
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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 13 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 12/13/2015
Initial Date OCFS Notified: 12/16/2015

Presenting Information

Subject mother reports early Sunday morning 12/13/2015, she found subject child lying on the living room floor at their home address. She thought the child was sleeping. When she realized subject child's lips were purple and subject child felt cold to the touch, subject mother called 911. An autopsy was performed on 12/15/2015. The Medical Examiner's office reported no signs of trauma. The cause of death is pending.

Executive Summary

This fatality review case involved a thirteen year old female subject child in an open SCR report investigation that passed away unexpectedly during the course of the investigation. The open 7/29/15 SCR report did not include the fatality incident and involved allegations of IFCS, IG, LSUP, and Parent D/A Misuse against subject mother (SM). A subsequent 9/8/15 report with allegations of IG and LBW against subject father (SF) was consolidated. There was no SCR fatality report made regarding this fatality. Buffalo Regional Office OCFS was notified of SC's death on 12/16/2015.

The open case investigation included appropriate case and collateral contacts including school personnel, family members, Pediatrician, law enforcement, first responders, and the Medical Examiner. Medical records, criminal background, SCR history checks, and documentation of case work activities were completed. There were no concerns reported by Pediatric or school personnel. The case record documented two significant lapses in case work contact. The first lapse involved a six day delay in case contact with the MA child and family after receipt of the 9/8/15 subsequent report and a 135 day lapse in contact with the subject of this report. The second lapse 9/28/15 – 12/16/15 is particularly significant because case work activity was renewed after learning SC had died. Required actions have been requested regarding both of these lapses in case work activity. The need to maintain on-going contacts to provide on-going safety and risk assessment is especially poignant in this instance as the possibility that an opportunity to avoid SC's circumstances of death may have been missed in this case.

Following the death of SC, the Caseworker made a home visit within 24-hours and assessed the safety of the surviving children. No safety concerns were documented. The SM reported leaving the home in the morning and returning a few hours later finding SC on the floor. She called 911 and EMS responded. First responders reported SC was non-responsive to resuscitation efforts and was DOA at the scene. SM reported no suicide note was found and no prior threat of suicide was made by SC, but SC did have a history of cutting and depression. SC's Aunt reported SC had talked about suicide with friends and had recently given away many of her personal items. This was discovered after her death. There were no signs of trauma or other suspicious indicators reported observed in the home by first responders or law enforcement personnel. No criminal charges were made.

The Medical Examiner performed an autopsy and her 3/3/16 final report listed the cause of death as Acute Desipramine intoxication. SC's source of this anti-depressant medication is unknown at this time as SM reported SC had no prescribed medications. The Medical Examiner's opinion statement reported no trauma or anatomic cause of death and a 2.9mg lethal level of Desipramine in SC's blood. A lethal dose is listed at 1-2mg. The manner of death is undetermined due to uncertainty regarding the intentionality of the overdose.

On 2/17/15, the open report was closed with allegations of IFCS, IG, LSUP, and Parent D/A Misuse against SM UNFOUNDED due to no credible evidence. Allegations of IG and LBW against SF were INDICATED. SC and siblings confirmed SF's actions, reported his intoxication, and an OOP was issued prohibiting SF's contact with SC. There was no SCR fatality report or criminal charges regarding the fatality of SC during the open report investigation. The source of the prescription Desipramine is unknown at this time and is of concern. Grief counseling was accepted by SM and preventive services were declined. The surviving children were determined as safe at case closing.

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:
This lack of activity during an open case investigation is more significant because the 2 1/2 month gap was also followed by SC's death on 12/13/15 which lead to the renewed case work contacts. Appropriate contacts may have provided an opportunity for assessment of service needs/ risks with SC. The lack of timely contact on the 9/8/15 subsequent report far exceeds State law mandates.

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 decision to close the case by the local district was appropriate.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	There was a significant gap in case work activity with no activity or face to face contacts with the

	children/adults for 2 1/2 months 9/29/15 - 12/16/15.
Legal Reference:	18 NYCRR 432.1 (b)(3)(ii)(a)
Action:	Regular case work contacts must be maintained in an open case investigation to appropriately provide on-going assessment of safety and risk.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	There was no contact with the MA child or assessment on the 9/8/15 subsequent report until six days after receipt of the report and no contact with the subject for 135 days.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	A 24-hour assessment should be completed on all SCR reports and contacts with MA children and report subjects should be timely.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/13/2015 **Time of Death:** Unknown

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: 10:38 AM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 3 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	13 Year(s)
Deceased Child's Household	Mother	No Role	Female	41 Year(s)
Deceased Child's Household	Sibling	No Role	Male	18 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)

LDSS Response

On 7/29/15, Erie Co. CPS received an SCR report with allegations of IFCS, IG, LSUP, and Parent D/A Misuse against subject mother (SM). A subsequent 9/8/15 report was consolidated. This report had allegations of IG and LBW against subject father (SF). During the course of these investigations, SC unexpectedly passed away on 12/13/15. There was no SCR fatality report made regarding this fatality. Buffalo Regional Office OCFS was notified of SC's death on 12/16/2015.

The CW made case and collateral contacts including school personnel, family members, Pediatrician, law enforcement, first responders, and the Medical Examiner. Medical records, criminal background, SCR history checks, and documentation of case work activities were completed. There were no concerns reported by Pediatric or school personnel.

The SC and two siblings reported that SC did provide care for her seven year old sibling while SM is at work, but was also assisted by her eighteen year old sibling. Ample food was observed in the home and the home appeared clean. SM and all children in the home denied SM's abusing alcohol or drugs. SM appeared sober on all case contacts. SM acknowledged calling SC an "ungrateful bitch" on one occasion due to SM buying clothes for SC and SC subsequently refusing to wear them. SM and SC denied any on-going verbal abuse.

Pertaining to the 9/8/15 subsequent report, a criminal OOP was issued after this incident prohibiting SF's contact with SC. SF did not reside in the SC's home. This incident occurred during a visitation. The children confirmed the allegations and reported SF was intoxicated. SC had no lasting injuries. SF denied the allegations and reported he had only defended himself regarding SC's friend that put his hands on him.

Following the death of SC, the Caseworker made a home visit within 24-hours and assessed the safety of the surviving children. No safety concerns were documented. The SM reported leaving the home in the morning to bring coffee to her father and returning a few hours later finding SC on the floor cold to the touch and with blue lips. She called 911 and EMS responded. SM and a neighbor attempted CPR until EMS arrived. First responders reported SC was non-responsive to resuscitation efforts and was DOA at the scene. SM reported no suicide note was found and no prior threat of suicide was made by SC, but SC did have a history of cutting/depression. SC's Aunt reported SC had talked about suicide with friends and had recently given away many of her personal items. This was discovered after her death. There were no signs of trauma or other suspicious indicators reported observed in the home by first responders or law enforcement personnel. No criminal charges were made.

The Medical Examiner performed an autopsy and her 3/3/16 final report listed the cause of death as Acute Desipramine intoxication. This is an anti-depressant and SC's source of this medication is unknown at this time as SM reported SC had no prescribed medications. The Medical Examiner's opinion statement reported no trauma or anatomic cause of death and a 2.9mg lethal level of Desipramine in SC's blood. A lethal dose is listed at 1-2mg. The manner of death is undetermined due to uncertainty regarding the intentionality of the overdose.

On 2/17/15, the allegations of IFCS, IG, LSUP, and Parent D/A Misuse against SM were UNFOUNDED due to no credible evidence to support the allegations. The allegations of IG and LBW against SF were INDICATED. SC and siblings confirmed SF's actions, reported his intoxication, and an OOP was issued prohibiting SF's contact with SC. There was no SCR report or criminal charges regarding the fatality of SC during the open report investigation. The source of the prescription Desipramine is unknown at this time and is of concern. Grief counseling was accepted by SM and services were declined. The case was closed with surviving children determined as safe at case closing.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Erie County Department of Social Services does not have an OCFS approved Child Fatality Review Team.

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:
To date, Law Enforcement did not file any charges in this case.

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 safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☒	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Explain:
There was no fatality SCR report regarding this family. The fatality occurred during an open SCR report investigation. The Caseworker did not learn of subject child's death until three days after the child had passed away. The caseworker did complete a home visit and safety assessment within 24-hours of it being learned that subject child had died. The surviving children were assessed as safe with no safety concerns present.

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to

				Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Explain as necessary:
There were no surviving children in the household that were removed as the result of this fatality incident, fatality investigation, or for any reason unrelated to this fatality.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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 Caseworker offered grief counseling services. Subject mother became suicidal and accepted grief counseling services and began this service before case closing. The children declined grief counseling services. The school was monitoring their status.

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:
Grief counseling and preventive services were offered for the surviving children by the caseworker, but were declined by the children and subject mother. The school did report the children appeared to be handling the situation and that they were monitoring this. Contact resource information, including a referral to the CAC, were provided to subject mother in case she wants such services in the future.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Subject mother made suicidal comments and did accept offered grief counseling for herself and began participation with a mental health provider. Preventive services were offered by the Caseworker, but were declined. Contact resource information, including a referral to the CAC, was provided in case the family decides to seek such services in the future.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/29/2015	8662 - Deceased Child, Female, 13 Years	8663 - Mother, Female, 41 Years	Parents Drug / Alcohol Misuse	Unfounded	No

8662 - Deceased Child, Female, 13 Years	8663 - Mother, Female, 41 Years	Lack of Supervision	Unfounded
8665 - Sibling, Male, 7 Years	8663 - Mother, Female, 41 Years	Inadequate Guardianship	Unfounded
8665 - Sibling, Male, 7 Years	8663 - Mother, Female, 41 Years	Lack of Supervision	Unfounded
8665 - Sibling, Male, 7 Years	8663 - Mother, Female, 41 Years	Parents Drug / Alcohol Misuse	Unfounded
8662 - Deceased Child, Female, 13 Years	8663 - Mother, Female, 41 Years	Inadequate Food / Clothing / Shelter	Unfounded
8662 - Deceased Child, Female, 13 Years	8663 - Mother, Female, 41 Years	Inadequate Guardianship	Unfounded
8665 - Sibling, Male, 7 Years	8663 - Mother, Female, 41 Years	Inadequate Food / Clothing / Shelter	Unfounded
8662 - Deceased Child, Female, 13 Years	8666 - Father, Male, 42 Years	Inadequate Guardianship	Indicated
8662 - Deceased Child, Female, 13 Years	8666 - Father, Male, 42 Years	Lacerations / Bruises / Welts	Indicated

Report Summary:
Allegations of Inad. F/C/S, IG, LSUP, and Parent's D/A Misuse against subject mother.

Subject mother is addicted to Loratab and is impaired by it while caring for subject child (13), and sibling (7). SC is responsible for watching sibling for twelve hours a day. SC is not responsible enough to provide care. SC cannot cook, so the children go all day without eating. They are hungry and are begging neighbors for food. SC is responsible for cleaning the house and helping her sibling with his homework. Sibling runs un-supervised in the street. Recently SC got lice and asked neighbor to treat her so SM would not get mad at her. SC is depressed. SM swears/curses at SC.

Determination: Unfounded | **Date of Determination:** 02/17/2016

Basis for Determination:
Through interviews with all relevant parties, collateral contacts, and home visits, it is determined that there is no credible evidence to support the allegations. The children acknowledged that SC does watch her younger sibling, but reported her older sibling, age 18, is also supervising with her while SM is at work. SM denied Lortab addiction for which she has a prescription. SM observed as sober on all drop-in home visits. Ample food supplies were observed in the home. SC has history of self-cutting, but no current such activity or depression. SM acknowledged calling child an "ungrateful bitch" on one occasion after buying clothes for SC and SC refusing to wear them.

OCFS Review Results:
No concerns are evident upon OCFS review.

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

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

There is a CPS history of two prior SCR reports involving this family that are more than three years prior to the fatality incident. These two reports are both UNFOUNDED. The two reports are as follows:

09/12/2012 Allegations of Lack of Supervision against subject mother and bio-father involving subject child's youngest

male sibling getting outside the home onto the neighbor's porch while the oldest sibling was supervising. Sibling was right behind him and child was not un-supervised. Services offered and declined. UNFOUNDED 09/18/2012.

08/18/2006 Allegations of Inadequate Food/Clothing/Shelter, Parent's Drug/Alcohol Misuse, Excessive Corporal Punishment ,and Inadequate Guardianship against subject mother and bio-father involving bio-father's discipline of oldest male sibling. Child had no marks or bruises. Bio-father acknowledged marijuana use, but not in presence of the children. Adequate food supplies were observed in the home. The children reported no concerns. Offered services were declined. UNFOUNDED 10/28/2006.

Known CPS History Outside of NYS

There is no known CPS history for this family outside of New York State.

Services Open at the Time of the Fatality

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** 12/13/2016
Explain: There was a criminal Order of Protection reportedly put in place against bio-father pertaining to no contact with subject child due to an SCR report where bio-father reportedly physically assaulted the subject child twisting her arm behind her back, pushing her against a wall, and throwing her to the ground.	

Additional Local District Comments

The Erie County Department of Social Services appreciates the review conducted by The Office of Child and Family Services for BU-15-042. We find that the facts are as stated and we are satisfied that the draft report describes the unfortunate event and the actions taken. We acknowledge that in the report dated July 29, 2015, we did not fulfill the need to make regular contacts with the family for whom we have an open investigation. Additionally, we concur with the reviewer's findings regarding the lack of timely contact with the maltreated child and the subjects of the report dated September 8, 2015. We are acutely aware of the need to make the required case contacts throughout the entire investigation and have already taken corrective action. A memo was distributed to all investigative staff by CPS' Administrative Director, on March 7, 2016. The memo reminded staff of the protocol with respect to contacts with children and families Involved in a CPS Investigation. Also, the matter had been addressed directly with the individual worker and supervisor assigned to this investigation. As OCFS is undoubtedly aware, caseload management is paramount in our minds, superseded in importance only by safety and risk management and family strengthening. We appreciate the opportunity to partner with OCFS in providing the best possible services to families in our community.

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