Child Fatality Report

Report Identification Number: BU-16-039

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

Issue Date: Mar 31, 2017 **(Report was reissued on: Apr 13, 2017)**

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
FM-Foster Mother	SS-Surviving Sibling	

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	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	

Case Information

Report Type: Child Deceased
Age: 0 day(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 11/09/2016
Initial Date OCFS Notified: 11/29/2016

Presenting Information

On 11/29/2016 the death of the SC was reported to OCFS because there was an open Child Protective Services (CPS) investigation with Erie County Department of Social Services (ECDSS) at the time. The open CPS investigation dated 10/20/2016, had allegations that the SM was physically abusive toward the one-year-old SS, recently the SS spilled her drink accidentally and the SM repeatedly hit the SS on her chest, face and shoulder, causing the SS's face to be red in color. The SS allegedly had scars on her legs from past beatings. It also alleged that the SM was abusing heroin and marijuana regularly. A subsequent SCR report was then received on 11/29/2016 that alleged on 11/09/2016 the SM gave birth to a baby boy (SC). The SM tested positive for marijuana at the time of the SC's birth. The SC was born at 22 weeks gestation, weighed only one pound and lived only a few hours before passing away. The subsequent report was merged into the initial SCR report.

Executive Summary

On 11/29/2016 the death of the SC was reported to OCFS in a 7065 form submitted by ECDSS. There was an open CPS investigation with ECDSS at the time of the SC's death. The open CPS investigation was received on 10/20/2016 with allegations that the SM was physically abusive toward the one-year-old SS.

The SC was born on 11/09/2016 at 22 weeks gestation, weighed only one pound and lived only about four hours before passing away. An autopsy was not performed and a toxicology was not done on the SC due to the gestational age. The SC was pronounced deceased by a hospital physician. The cause of death was listed on the death certificate as pre-term labor. It was determined by a medical physician that there was no evidence that the SM's marijuana use caused the SC's prematurity nor subsequent death. Law enforcement was not involved as there was no evidence the SC died due to the actions or inactions of the SM.

The SM and SS were in a homeless shelter at the time of the SC's birth. They moved in with the MGM for support after the death of the SC. ECDSS adequately assessed the safety of the SS and assessed the MGM's home to be safe. ECDSS conducted several full body assessments of the SS and observed no marks, bruises or scars. All collaterals contacted had no concerns for the SS's safety or that the SM used excessive discipline or used drugs. The SM engaged in substance abuse treatment, and although continued to test positive for marijuana, voiced a desire to continue with treatment. The SM was on a waiting list for a transitional shelter that would provide her and the SS with housing and intensive case management services.

ECDSS contacted the necessary collaterals and gathered the documentation to support their determination. ECDSS offered preventive services to the SM and she refused. ECDSS consulted with legal and then unfounded and closed the case, sending a letter to the SM recommending that she follow all drug treatment recommendations and provided the SM with information on grief counseling. ECDSS did not make any attempts to interview the BF of the SS, whom the SM reported may also be the BF of the SC. The BF could have had important information to share pertaining to the care of the SS and the SM's drug use. Bereavement services and support should have been offered to the BF as well.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** 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:
Sufficient information was gathered to assess safety of the SS and unfound the allegations.

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:
The decision to close the case was appropriate. The SM refused services and ECDSS was unable to take legal action.

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: 11/09/2016 **Time of Death:** 08:00 AM

County where fatality incident occurred: ERIE
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
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? No - Not needed given developmental age or

circumstances

Total number of deaths at incident event:

Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Male	4 Hour(s)
Deceased Child's Household	Mother	No Role	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Other Household 1	Father	No Role	Male	36 Year(s)

LDSS Response

ECDSS was notified by the MGM on 11/10/2016 that the SM gave birth to the SC four months prematurely on 11/09/2016 and that the SC was only one pound and was allegedly stillborn. The MGM stated that the SM said she thought she heard the baby cry but the SM was wrong as the baby was stillborn. The MGM stated that the SM made a suicidal comment that resulted in the SM having a psychiatric evaluation and that she had the SS with her until the SM was "out and stable".

ECDSS contacted the SM on 11/22/2016, when they interviewed her and the MGM at the MGM's home. The one-year-old SS was observed at this home visit. The SM stated that the SC lived for several hours after birth and was not stillborn. The SM stated that the SC was born prematurely and that there was nothing anyone could do, stating that the SC's heart stopped and his lungs stopped breathing. The SM stated that she and the SS were now living with the MGM and no longer staying in the homeless shelter. The MGM's home was assessed to have no safety hazards and the SS was assessed to be safe.

ECDSS followed up with hospital staff to gather more information on 11/29/2016. At this time it was learned that the SC was born prematurely at 22 weeks gestation and lived several hours before passing. It was also learned that the SM tested positive for marijuana at the time of the SC's birth and that an autopsy and toxicology were not done on the SC due to the gestational age. ECDSS notified OCFS of the fatality at this time. A subsequent SCR report was received with the allegation of PD/AM against the SM regarding the SC. ECDSS made another home visit at the MGM's home to again assess the safety of the SS. The home was assessed to have no safety hazards and the SS was assessed to be safe. ECDSS advised the SM to obtain a substance abuse evaluation and to take the SS for a medical exam to assess her safety. The SM stated that she had already begun substance abuse treatment. The medical exam was later conducted and the SS was assessed to be healthy with no medical concerns.

ECDSS spoke extensively with the hospital staff regarding the circumstances of the SC's birth and death. ECDSS verified that the SC's death was due to a medical cause associated with the prematurity and not correlated with the SM's positive toxicology. ECDSS gathered medical records for the SC and SS, obtained the death certificate, checked the SM's criminal background, and reviewed CPS history for the SM, MGM and BF. They spoke to multiple collaterals including the MGM, shelter staff, hospital staff, SS's pediatrician and SM's substance abuse counselor. ECDSS verified that the SM was regularly attending substance abuse services and was on a waiting list for a transitional shelter for her and the SS, that would provide the SM with intensive case management services. ECDSS offered preventive services to the SM and when

she refused, ECDSS consulted with legal. Upon the closing of the case, ECDSS sent a letter to the SM providing her with information on grief counseling and recommending that she comply will all treatment recommendations of her substance abuse treatment provider. ECDSS accurately unsubstantiated the allegations against the SM regarding the SC, as there was a lack of evidence that the SM's marijuana use had an impact on the SC.

ECDSS didn't attempt to engage the BF of the SS. ECDSS was notified by the SM that the same man may be the BF of the SC and ECDSS didn't attempt to interview him, verify paternity or offer support or bereavement services. ECDSS failed to obtain additional information regarding the SM's arrest on 06/25/2016 in the presence of the SS. This information could have been pertinent to the investigation.

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 reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Erie County does not have an 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:
The SC was born prematurely at the hospital and not discharged prior to his death a few hours later. The SC was not observed by ECDSS. LE was not involved. There was no evidence the death was due to any actions or inactions of the SM.

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?	☐	☐	☒	☐

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 children removed due to the fatality.				

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	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:
SM engaged in drug treatment services and was on a waitlist for intensive case management and housing services. Grief counseling information was provided to the SM but it's unknown if she utilized this service. ECDSS provided the SM with financial assistance for the funeral services and cremation. After the fatality occurred the SM and SS went to stay

with the MGM as they were previously homeless.

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? N/A
Explain:
The SS required no services due to her young age.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SM obtained financial assistance from DSS for funeral home and cremation costs. ECDSS provided the SM with information on grief counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☒ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

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)
10/20/2016	13952 - Sibling, Female, 1 Years	13951 - Mother, Female, 26 Years	Inadequate Guardianship	Unfounded	Yes

13952 - Sibling, Female, 1 Years	13951 - Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unfounded
13953 - Deceased Child, Male, 4 Hours	13951 - Mother, Female, 26 Years	Parents Drug / Alcohol Misuse	Unfounded
13952 - Sibling, Female, 1 Years	13951 - Mother, Female, 26 Years	Lacerations / Bruises / Welts	Unfounded

Report Summary:
The SCR report alleged the SM was physically abusive toward the one-year-old SS. Recently the SS spilled her drink accidentally and the SM repeatedly hit the SS on her chest, face and shoulder, causing the SS's face to be red in color. The SS had scars on her legs from past beatings. It also alleged that the SM was abusing heroin and marijuana regularly. A subsequent report was received on 11/29/2016 that alleged on 11/09/2016 the SM gave birth to a baby boy (SC). The SM tested positive for marijuana at the time of the SC's birth. The SC passed away a few hours later as a result of being born at 22 weeks gestation. The subsequent report was merged into the initial report.

Determination: Unfounded | **Date of Determination:** 12/20/2016

Basis for Determination:
ECDSS Unsub the allegations of PD/AM, IG and L/B/W regarding the SS and PD/AM regarding the SC. ECDSS determined there was a lack of credible evidence and Unsub the allegations. The SS was observed to have no marks, injuries or scars. The collaterals interviewed had no concerns for SM using physical discipline on the SS or using drugs. Although SM tested positive for pot, it was deemed to have no correlation with the SC being born prematurely or passing away. SM refused preventive services but was on a waiting list for a transitional shelter that would provide the intensive case management the SM needs. SM was engaged in drug treatment. After a legal consult the case was closed.

OCFS Review Results:
The decision to Unsub the allegations was warranted and supported by the lack of evidence that the SM's marijuana use had a negative impact on the children or that the SM used excessive discipline on the SS. ECDSS spoke to numerous collaterals and gathered sufficient documentation to support the determination. ECDSS made the appropriate referrals for grief counseling and intensive case management services for the SM. ECDSS failed to engage and interview the BF of the children. ECDSS failed to further investigate the SM's criminal charges from 06/25/2016, which may have yielded pertinent information.

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

Issue:
Face-to-Face Interview (Subject/Family)

Summary:
ECDSS failed to engage and interview the BF of the children. ECDSS therefore failed to offer support or bereavement services to the BF. The BF could have had important information pertaining to the care of the SS and the SM’s drug use.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(a)

Action:
ECDSS will make diligent efforts to engage and interview the BF of children named in reports. ECDSS will offer bereavement services and support to all biological parents of children named in fatality reports.

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
ECDSS failed to fully investigate the SM's criminal background. LE records revealed that the SS was present for an incident on 06/25/2016, where the SM was arrested for assaulting and harassing two individuals. This information may have been pertinent to the investigation. ECDSS did not follow up to find out what the disposition was.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:

ECDSS will conduct thorough investigations and will fully investigate all emerging safety concerns.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/07/2015	12494 - Sibling, Female, 7 Months	12491 - Mother, Female, 25 Years	Inadequate Guardianship	Unfounded	Yes
	12494 - Sibling, Female, 7 Months	12491 - Mother, Female, 25 Years	Parents Drug / Alcohol Misuse	Unfounded	
	12494 - Sibling, Female, 7 Months	12491 - Mother, Female, 25 Years	Lack of Medical Care	Unfounded	

Report Summary:

The SCR report alleged that the SM and 3 parent substitutes used coke, pills and marijuana until they were impaired while caring for SS, age 7 months, on a daily basis. SM engaged in a physical fight with parent substitute 1 in SS's presence. SM had a black eye as a result. SM took SS with her to a crack house where SM used drugs. SS had a respiratory cold for about 2 weeks. SS had a deep cough, congestion and couldn't lay on her back. SM refused to bring SS for medical treatment. SM sold her food stamps and fed SS regular table food. It was unknown if SS was getting appropriate nutrients. Add info rec'd 12/14/2015 SM's face was cut by an unknown male during a friend's home invasion.

Determination: Unfounded | **Date of Determination:** 03/14/2016

Basis for Determination:

The 3 male subjects were determined to be reported in error and their allegations were removed. ECDSS Unsub the allegations of LMC, IG and PD/AM against the SM based on the SM denying knowing who the 3 males were and denying all allegations. SM and SS were observed to have no marks and SS was seen by the doctor who had no medical concerns for SS. SM had plenty of formula and baby food. SM became homeless in December 2015 then moved to Chautauqua Co. to a friend's home in January 2016. The friend's home was assessed to be safe by a CW, the SM denied a need for services and the case was closed.

OCFS Review Results:

After the SM was assaulted by a male at a friend's home, the friend was not interviewed. The source of the information was not spoken to, to gather more information on the male who took the SS after the incident. There was no follow up regarding drugs possibly being involved. MGM wasn't interviewed about the fight with SM. The CW didn't consult with legal after directed to by a supervisor on 12/14/15. The CW didn't attempt to contact SM for 2 months after learning she was homeless. The CW found out on 2/8/15 the SM moved out of county and entered a progress note on 3/14/15 a legal consult wasn't done due to the move. Some progress notes were entered up to 3 months after the event date.

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

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

ECDSS failed to contact significant collaterals and did not follow up with a source to gather pertinent information.

Legal Reference:

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

Action:

ECDSS will contact all significant collaterals and sources of reports in order to gather pertinent information to complete a thorough investigation.

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:
ECDSS did not enter all progress notes contemporaneously, some were entered up to 3 months after the event date.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
ECDSS will record all progress notes contemporaneously.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
ECDSS did not follow up on concerns that arose surrounding possible drug use and criminal activity taking place in the presence of the SS. ECDSS CW did not consult with legal after being given a directive to do so by a supervisor. The CW entered a note 3 months later this wasn't done due to the SM moving out of county. The CW was not aware of the move until almost 2 months after the directive.
Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:
ECDSS must conduct complete and adequate CPS investigations, consulting with legal when necessary.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/18/2015	12523 - Sibling, Female, 1 Months	12522 - Mother, Female, 24 Years	Lack of Supervision	Unfounded	Yes
	12523 - Sibling, Female, 1 Months	12522 - Mother, Female, 24 Years	Inadequate Guardianship	Unfounded	

Report Summary:
SCR report received with allegations the SM got into a physical altercation with an unknown individual while out in the community with one-month-old SS. During this altercation SM left SS unsupervised in her car.

Determination: Unfounded | **Date of Determination:** 05/28/2015

Basis for Determination:
ECDSS Unsub SM for IG and LS regarding SS based on the SM denying that she left SS unattended in a car, stating that she does not have a car and had to get rides from her aunt. SM denied having a physical altercation with someone and police records didn't reveal any such incident occurring. SM declined the need for services and the case was UNF and closed.

OCFS Review Results:
ECDSS Unsub the allegations without speaking to the SM's aunt about the allegations. SM's aunt gave the SM rides and may have witnessed the incident. SM was on probation for selling crack. SM completed drug treatment and was successfully discharged from probation at the end of the investigation. ECDSS obtained and reviewed LE records. ECDSS spoke to SM's MH counselor who stated that SM was discharged for not showing up to appointments and felt SM needed counseling. ECDSS followed up with the pediatrician and spoke to the visiting nurse to ensure there were no concerns for the SS. The CW made diligent effort to locate the alleged BF's address but was unsuccessful.

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

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
ECDSS did not contact the aunt, a pertinent collateral, in order to conduct a thorough investigation. The SM's aunt

transported the SM in her car and may have been a witness to the incident.

Legal Reference:

SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:

ECDSS will conduct thorough investigations and will contact all pertinent collaterals to investigate the allegations.

[redacted]

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

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

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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? There was no legal activity

Additional Local District Comments

Although multiple compliance concerns were noted in this review, the timeframe encompassed a number of reports over a 3 year period related to this family. These investigations were conducted during a time of extremely high caseloads in our county, as OCFS is aware. ECDSS respectfully disagrees with some of these findings. We find it excessive to cite ECDSS for having late entry of notes when only a few of many were entered late; for not consulting the legal department about a family who was no longer under our jurisdiction and assessed to be safe in their new jurisdiction; and for not consulting a source who failed to respond to our attempt at contact and from whom we had a written report. We agreed with the citation regarding some of the missing collateral contacts, but would note that during the 3/18/15 case there were numerous collaterals contacted and yet ECDSS was still cited. We will reference in our CAP the many steps taken to address these concerns in recent years. Our Quality Assurance Plan developed previously with OCFS continues to monitor our work to address concerns noted in this review and is the vehicle by which we identified some of these issues prior to this report.

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