Child Fatality Report

Report Identification Number: BU-17-003

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

Issue Date: Jun 22, 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: 7 month(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 03/01/2017
Initial Date OCFS Notified: 03/01/2017

Presenting Information

An SCR report was received on 3/1/17. The report alleged the SM and parent substitute (PS) went to sleep on a couch with the SC in the attic of the home. The report stated the attic was very warm and around 6:30a.m the PS woke up to turn the heat down. The PS found the SC on the floor, unresponsive, with vomit around her mouth. The SM carried the SC's body downstairs and called 911. The police and medical personnel responded and did CPR on the SC, but the SC was deceased before they arrived at the home. The SC had no preexisting health condition and was a healthy child. The roles of 17-year-old OC and 3 and 7-year-old SS were unknown.

Executive Summary

This fatality report concerns the death of the 7-month-old SC, reported to the SCR on 3/1/17. The report alleged that the SM and Parent Substitute (PS) slept on the couch with the SC in a very warm attic bedroom. On the evening of 2/28/17 the SM fed the SC and then placed her to sleep on a leather couch covered by a loose fitting sheet. The couch was located in a finished attic bedroom, along with an adult bed where the SM and PS slept. The SM and PS went to sleep in their bed a couple of hours later. The PS awoke in the morning to turn down the electric heater and found the SC lying on the couch unresponsive. The SC had vomit around her mouth and vomit was also on a blanket on the couch. The PS woke up the SM and the SM took the child downstairs, placed her on an ottoman and began to try to resuscitate her while the PS called 911.

EMS and LE responded to the home and were unable to revive the SC, despite valiant efforts. Also present in the home at the time of the fatality were the PS's 17-year-old child (OC) and the 7-year-old and 3-year-old SS. The OC and eldest SS awoke to the noise in the home and were made aware of the death of the SC. ECDSS conducted an investigation jointly with LE. ECDSS promptly interviewed the OC at the home and also interviewed the SS at the Child Advocacy Center (CAC). ECDSS arranged for the SS to have medical exams while at the CAC and asked the PS to have the OC seen by his doctor. ECDSS also located and assessed the safety of the PS's children living outside the home.

ECDSS interviewed appropriate collaterals, including first responders, medical professionals, school staff, relatives and the ME. ECDSS reviewed medical records, police records and CPS records as part of the fatality investigation. ECDSS completed safety and risk assessments timely and adequately.

The final autopsy report was completed at the time of this report, but was not available before ECDSS made a determination in the case. The ME determined the manner of death to be natural and the cause to be acute bronchopneumonia. The ME previously told ECDSS the SC died naturally and reported the toxicology reports were negative and the SC had no injuries. At the time the determination was made regarding the SCR report allegations, the ME was unable to say if the SC sleeping on the sofa was a contributing factor to her death, because the child was developmentally able to roll over from front to back and was found face up. Criminal charges were not pursued against the SM or PS because LE ruled out homicide and concluded the SC died of natural causes in her sleep.

ECDSS indicated the report against both the SM and PS regarding the death of the SC. ECDSS based the determination on the aggravating factors that were present at the time of the fatality. Specifically, ECDSS found there

was some credible evidence suggesting the warm temperature of the bedroom and the couch where the SC slept contributed to her death. ECDSS documented the SM had a crib for the child, but had not taken it out of storage. Both the PS and SM had received safe sleep education.

ECDSS offered counseling and bereavement services to the family. The eldest SS was receiving counseling at the time of this report. ECDSS also offered the family preventive services, but the SM and PS declined.

OCFS review of the family's history with ECDSS resulted in a citation regarding the timeliness of safety assessments. In response, ECDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action the Regional Office has taken, or will take, to address the cited issue. For citations where a PIP is currently implemented, ECDSS will review the plan and revise as needed to further 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

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:

There were face to face interviews done with all subjects and children. ECDSS identified and interviewed collateral contacts. Ongoing services from ECDSS were offered to the family and they declined. There is documented regular supervision with clear direction throughout the fatality investigation.

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: 03/01/2017 **Time of Death:**

County where fatality incident occurred: ERIE
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to respond to the scene? Yes
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 - but needed
At time of incident supervisor was:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	7 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Other	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Other Child	No Role	Male	17 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Father	No Role	Male	31 Year(s)

LDSS Response

On 3/1/17 ECDSS received an SCR report regarding the death of the SC and promptly began their investigation by contacting the source, LE, the DA and ME. ECDSS visited the case address and were able to interview the OC. ECDSS then contacted relatives and were able to see and interview the two SS. The OC and SS were present in the home when the fatality occurred. The OC reported he was sleeping and awoke early in the morning to the SM screaming about the SC not breathing. The OC told ECDSS that EMS and LE were there when he came out of his room and LE spoke with him. ECDSS interviewed the SS, but only the eldest was verbal during the interview. The SS reported that he, the other SS and

the SC spent the night at the PS's home. The SS said the SC slept on a couch and had no crib at the home, because the crib was in storage.

ECDSS spoke with the SM and PS separately after they spoke with LE. The SM stated she and the children were starting to move into the PS's home, and the night before the fatality was the first night they spent there. SM stated the two SS slept in a bedroom together and the OC had his own room. The SM and PS slept in a finished attic bedroom, and the SC was in the same room. The SM placed the SC to sleep on a leather couch covered with a loose fitted sheet, after feeding her. The SM awoke in the early morning hours to the PS yelling and crying, and he said there was something wrong with the SC. The SM told ECDSS she jumped out of bed and ran to the couch. The SM said there was vomit on the sheet where the SC was sleeping. She told ECDSS she took the SC from the arms of the PS and carried her downstairs to begin CPR. The SM reported being distraught during this time. The PS called 911 while this was happening. The SM said that when LE and EMS arrived they tried to revive the SC. The PS told ECDSS that he and SM went to bed after 1:00 am and the SC was last fed by the SM around 11:00 pm and was then asleep on the couch. The PS said he woke up around 6:30 am to turn down the electric heater in the room because he was too hot. At that time the PS reported checking on the SC and saw her lying face up on the couch with vomit in her mouth, so he picked her up and woke up the SM. The PS had the same explanation of events that the SM did. The SM and PS both told ECDSS that the eldest SS woke up and came downstairs when the SM was yelling about the SC being gone. The other SS was in his room asleep and the OC was awake, emerged from his room to get ready for school and went back into his room when he heard the commotion.

The SC was reportedly a happy and active baby that slept through the night. The SC was not taking any medications and was an otherwise healthy child. The SM and PS were aware of safe sleep practices. The SC normally slept in a crib, but the crib was in storage since the SM and the children were just beginning to move into the home of the PS. ECDSS gave both the SM and the PS information regarding safe sleep, in addition to other educational material regarding the care of children. The SM and PS both denied any alcohol or drug use at the time of the fatality, or any history of misuse.

ECDSS had contact with the BF of the SC and SS. The BF had regular visitation with all the children and reported the SC slept in a pack and play while at his home. The BF also denied any drug or alcohol misuse.

ECDSS had contact with LE throughout the investigation. LE did not feel the death of the SC was suspicious and closed their investigation. ECDSS received additional information from LE that a blanket with vomit was found on the couch where the SC was sleeping. The blanket was taken as evidence. ECDSS concluded that first responders arrived at the home around 6:49 am and found the SC on an ottoman in the living room, where the SM had taken her to do CPR. EMS tried to revive the SC, but she was already deceased when they arrived.

After assessing the needs of the family, ECDSS referred the family for services.

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: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
037021 - Deceased Child, Female, 7 Mons	037022 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
037021 - Deceased Child, Female, 7 Mons	037023 - Other - Parent Substitute, Male, 39 Year(s)	DOA / Fatality	Substantiated
037021 - Deceased Child, Female, 7 Mons	037023 - Other - Parent Substitute, Male, 39 Year(s)	Inadequate Guardianship	Substantiated
037021 - Deceased Child, Female, 7 Mons	037022 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated

CPS Fatality Casework/Investigative Activities

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

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?	☐	☒	☐	☐

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	☐	☒	☐	☐	☐	☐	☐

Other, specify: Preventive Services

Additional information, if necessary:
The SS was misbehaving in school after the fatality and ECDSS spoke with the school and confirmed he was seeing a counselor there. The school counselor told ECDSS referrals for counseling while school is not in session would be sent home for the SS. ECDSS spoke with the SM about the concerns the school had regarding the SS. ECDSS encouraged continued counseling for the SS. The SM agreed.

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? No
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)
01/16/2016	15272 - Other Child - OC living with SC, Male, 16 Years	15271 - Other Adult - Stepmother to OC, Female, 31 Years	Inadequate Guardianship	Indicated	Yes
	15273 - Other Child - Stepmother's Child, Male, 10 Years	15271 - Other Adult - Stepmother to OC, Female, 31 Years	Inadequate Guardianship	Indicated	

Report Summary:
An SCR report with allegations of IG against the stepmother of the OC (this child resided in the home with the SC at the time of her death). The allegations were regarding the child of the stepmother and the OC. The report alleged that on 1/16/16 at about 4:50PM, a ten-year-old child found the body of his mother. She had committed suicide by hanging herself in the attic. Both children were in the home at the time of her suicide. The stepmother had a history of MH concerns and was on medication.

Determination: Indicated
Date of Determination: 04/18/2016

Basis for Determination:
ECDSS found that the stepmother did in fact commit suicide in the home while she was the sole caretaker for the 2 children. The children were unrelated, and therefore taken into the homes of respective family members. The BF of the OC was incarcerated and planned to get custody when he was released. The stepmother's child went to reside with his maternal grandparents. ECDSS found the stepmother had a history of MH issues and suicidal ideations.

OCFS Review Results:
ECDSS contacted the source, the BF, relatives and the school as collaterals. Notice of existence letters were sent to both BF's and the subject. The children were both interviewed and caregivers were given resources for grief counseling,

considering the traumatic events. ECDSS spoke with family court staff to verify relatives had filed for and were granted Article 6 custody of the children. Home visits were done with both children and they appeared to be adjusting well to their new environments. The safety assessments and RAPS were completed accurately, but not always timely.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-day safety assessment was not completed within the specified time period.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
ECDSS will complete safety assessments within the allotted time frame.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/28/2014	15159 - Sibling, Male, 4 Years	15160 - Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unfounded	No
	15162 - Sibling, Male, 10 Months	15160 - Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	15162 - Sibling, Male, 10 Months	15160 - Mother, Female, 20 Years	Inadequate Guardianship	Unfounded	
	15162 - Sibling, Male, 10 Months	15160 - Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unfounded	
	15159 - Sibling, Male, 4 Years	15163 - Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	15162 - Sibling, Male, 10 Months	15163 - Father, Male, 29 Years	Inadequate Food / Clothing / Shelter	Unfounded	
	15159 - Sibling, Male, 4 Years	15160 - Mother, Female, 20 Years	Inadequate Guardianship	Unfounded	
	15159 - Sibling, Male, 4 Years	15160 - Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unfounded	
	15159 - Sibling, Male, 4 Years	15163 - Father, Male, 29 Years	Inadequate Guardianship	Unfounded	
	15159 - Sibling, Male, 4 Years	15163 - Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unfounded	
	15162 - Sibling, Male, 10 Months	15163 - Father, Male, 29 Years	Inadequate Guardianship	Unfounded	
	15162 - Sibling, Male, 10 Months	15163 - Father, Male, 29 Years	Parents Drug / Alcohol Misuse	Unfounded	

Report Summary:
An SCR report with allegations of IG, IF/C/S and PD/AM against SM and BF regarding the two SS. It was alleged they argued and threw things at each other in front of the two SS. It reported SM and BF smoked marijuana regularly, spending all their money, so there was no food in the home. It was said one of the SS was extremely thin and appeared malnourished. SM and BF ignored the needs of the children while they were smoking marijuana. The children were left in their rooms for unknown lengths of time and the 5-yr-old SS was often made to care for the 8-month-old SS.

Determination: Unfounded	**Date of Determination:** 03/10/2015
Basis for Determination: ECDSS interviewed both subjects, collateral contacts, and the child that was verbal. The SM and BF denied the allegations and each time that ECDSS visited the home the parents were found sober and the children well cared for. There was no credible evidence to substantiate the allegations.	
OCFS Review Results: ECDSS interviewed both subjects and did several announced and unannounced home visits. All safety and risk assessments were completed on time and with accuracy. The source was contacted, as were several other collateral contacts, such as family members, law enforcement and medical providers.	
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No	

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

An SCR report was received on 8/27/12 with allegations of IG, IF/C/S and LM against SM regarding a SS. All allegations were unsubstantiated.

Known CPS History Outside of NYS

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

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.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Additional Local District Comments

We at the Erie County Department of Social Services (ECDSS) find that the facts as written describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality. Subsequent to the determination of this investigation the autopsy was received which provided new insight into the cause of death which was determined to be acute bronchopneumonia. The parents will be notified so that they may proceed with the process of having the case determination reviewed in light of these new facts. With regard to the family's prior history, it was found that a past case dated June 16, 2016 had a safety assessment that was not submitted and approved within the required seven day time

frame. We unfortunately concur with this finding, while noting that concerns with regard to timely safety assessments have already been addressed in a Program Improvement Plan that was completed subsequent to this historical investigation. The county's Quality Assurance Program is ongoing and continues to monitor the timeliness of safety assessments. We at ECDSS constantly strive for improvements in timeliness and service delivery, including the timely completion of safety assessments. Consistent reminders regarding this topic are circulated via email and during regular meetings. We appreciate the opportunity to partner with OCFS in providing the best possible service 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