Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-24-017

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

Issue Date: Jan 07, 2025

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: 11 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 08/09/2024
Initial Date OCFS Notified: 08/09/2024

Presenting Information

An SCR report alleged the 11-month-old child was diagnosed with a neurological disorder and a genetic condition. The mother was aware that the child required a g-tube as a result of his medical needs. Sometime between 08/05/24 and 08/07/24, the child was without his g-tube. As a result, while in the care of the mother, the child was not fed for 2 days. The mother gave the child medication orally, which was against medical recommendations. On 08/08/24, the child was brought to the hospital after suffering a medical event due to his neurological disorder, and the mother left the hospital before the child was evaluated. The child passed away on 08/09/24 as a result of the mother's ongoing failure to follow through with the child's medical needs.

Executive Summary

This report concerns the death of the 11-month-old child that occurred on 08/09/24. A report was made to the SCR on the same day alleging the mother was not adequately attending to the child's medical needs. At the time of the child's death, there was an open Preventive Services Case as a result of the mother's mental health and drug misuse. At the time of the child's death, he resided with the mother and 3 and 12-year-old siblings. A 17-year-old sibling resided outside of the home. The safety of the siblings was assessed and resulted in a Safety Plan being implemented. The mother agreed to properly supervise the siblings who resided in the home and provide them with a safe living environment.

Erie County Department of Social Services (ECDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. At the time of this writing, the criminal investigation remained pending. An autopsy was performed; however, the autopsy report was not yet available at the time of this writing. The medical examiner reported it was unlikely the child died as a result of the unsafe sleeping environment in which he was placed.

The mother was interviewed and reported placing the child to sleep on his back and on an adult bed around 3:00 AM, and around 9:00 AM, a service provider arrived at the home and discovered the child unresponsive. The service provider contacted 911 and administered CPR until first responders arrived and took over resuscitation efforts. The child was pronounced deceased at the home.

ECDSS contacted the service provider who discovered the child unresponsive, the case planner, the Early Intervention worker, and the maternal grandmother. There were not concerns for the care the mother provided to the children. They denied seeing the child sleeping on the bed prior to the death. Hospital staff was interviewed and reported the grandmother had concerns for the mother's mental health and that the mother struggled to comply with medical recommendations for the child.

The allegations of Lack of Medical Care and DOA/Fatality were unsubstantiated. Inadequate Guardianship was substantiated. The Investigation Conclusion Narrative stated Inadequate Guardianship was substantiated as there was a fair preponderance of evidence that the mother was advised on unsafe sleeping practices yet placed the child in bed next to her while they both slept. ECDSS documented that "the concept of co-sleeping is considered a contributing factor to [the child's] passing." The allegations of Lack of Medical Care and DOA/Fatality were unsubstantiated. The mother brought the child for medical attention, and she was trained on how to properly use the child's medical equipment. The mother properly sought medical attention for the child.

ECDSS completed required reports timely and with accuracy. Home visits were made, and the siblings were assessed throughout the investigation. The family was offered and accepted bereavement services. The investigation was closed timely, and the Services case remained open at the time of this writing.

PIP Requirement

ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the 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:
The case remained open for Services.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/09/2024 **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: 09:39 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	11 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

On 08/09/24, ECDSS received the SCR report. Within the first 24 hours of the investigation, ECDSS contacted the source of the report, notified the medical examiner and district attorney's offices of the death, and documented a CPS history check. The siblings were assessed and remained in the care of the mother and maternal grandmother.

ECDSS gathered information from a hospital social worker. The social worker said that the grandmother told hospital staff

that the mother had mental health concerns and needed to be shown how to use the child's medical equipment, and the mother was not properly feeding the child. The mother brought the child to the hospital on 08/07/24 and was shown how to use the child's medical equipment and the child was discharged. On 08/08/24, the mother brought the child back to the hospital as she thought the child had a neurological event. The mother then left the child at the hospital so she could care for the siblings at home. She later returned to the hospital and brought the child home.

On 08/10/24, ECDSS interviewed the mother. The mother stated that on 08/07/24, she was given a piece of medical equipment that the child needed, and she was educated on how to use it. On 08/08/24, the child had a neurological event that was accompanied by a fever. She left the child at the hospital to tend to the siblings. The mother said on 08/09/24, the mother fed the child around 2:00 AM and then they both went to sleep on the same bed. Around 9:00 AM, a service provider arrived for a scheduled appointment. The service provider found the child on the bed, unresponsive. The mother was unaware the child was deceased. The grandmother was present at the time of the interview and accepted bereavement referrals on behalf of the family. The record did not reflect the grandmother was asked about the child not being fed; however, the grandmother did not express concerns for the mother's ability to care for the child or for her mental health. The 17-year-old sibling lived with the paternal grandmother. She reported she saw the child the day prior to the death, and he was ok. The siblings who resided in the home were assessed to be safe in the care of a relative via FaceTime and were later observed in person.

The medical examiner reported there were no injuries to the child and that he had "foam" in his mouth due to moisture in his lungs, possibly caused by a seizure. The medical examiner reported it was likely that the child died a few hours prior to being discovered.

ECDSS interviewed the service provider who discovered the child unresponsive. He reported arriving at the home and the child did not look "normal." He touched the child, and he was stiff. He alerted the mother, called 911 and began CPR. The service provider said the mother reported the child was sleeping more often and he believed the mother was doing well with the child's medical needs. He did not have concerns for substance abuse or the mother's mental health.

ECDSS spoke with the case planner of the Preventive Services Case. The case planner noted that the mother acted appropriately when feeding and positioning the child. The case planner did not see the child sleeping on a bed, nor did she have concerns for the mother's mental health or possible substance abuse. The Early Intervention worker did not have concerns for the child.

ECDSS appropriately determined the allegations based on information gathered during the investigation. The investigation was closed timely, and the Services case remained open.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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 death was referred to an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069537 - Deceased Child, Male, 11 Month(s)	069538 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
069537 - Deceased Child, Male, 11 Month(s)	069538 - Mother, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
069537 - Deceased Child, Male, 11 Month(s)	069538 - Mother, Female, 36 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?	☒	☐	☐	☐
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 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 children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
The surviving children were not removed.

Legal Activity Related to the Fatality

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

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
It remained unknown if the eldest sibling engaged in bereavement services.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The mother was offered grief counseling and burial assistance. The mother accepted the referrals.

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)
06/07/2024	Deceased Child, Male, 9 Months	Mother, Female, 36 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 9 Months	Mother, Female, 36 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
An SCR report received on 6/7/24 alleged that the 9-month-old child fell ill and was admitted to the hospital. The child had multiple medical diagnoses. The mother's behavior was inappropriate and dangerously interfered with the child's medical care. The mother repeatedly picked up the child while he was receiving his medical treatments. The mother repeatedly climbed in the child's crib and removed his breathing mask. The mother exhibited volatile and out of control behavior while in the child's room and had to be removed.

Report Determination: Indicated

Date of Determination: 07/12/2024

Basis for Determination:
The allegation of Lack of Medical Care was unsubstantiated. The Investigation Conclusion Narrative stated the mother brought the child to the hospital and responded appropriately when she noticed the child was lethargic. Inadequate Guardianship was substantiated. The investigation revealed the mother took off the child's breathing mask and was erratic. It was documented that the mother had untreated mental health concerns that impacted her ability to understand the child's needs.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A mental health referral was made for the mother and safe sleep information was provided. The mother was referred to a counselor and the Services case remained open.

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)
02/02/2024	Deceased Child, Male, 5 Months	Mother, Female, 36 Years	Choking / Twisting / Shaking	Substantiated	Yes
	Deceased Child, Male, 5 Months	Mother, Female, 36 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report alleged that on 02/02/24, the child was brought to the hospital for a neurological concern. The child was diagnosed with a genetic condition. For an unknown reason, while in the waiting room, the mother was observed shaking the child for approximately five seconds. The mother closed the door when she observed someone was watching her. It was unknown if the child sustained any injuries as a result.

Report Determination: Indicated | **Date of Determination:** 03/20/2024

Basis for Determination:
The allegations were substantiated as the investigation revealed a fair preponderance of evidence. The Investigation Conclusion Narrative stated the mother discontinued administering the child's medication as he was doing better. The mother appeared developmentally delayed and overwhelmed by the child's medical conditions.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check was completed. ECDSS created and implemented a Safety Plan. A Neglect Petition was filed against the mother and an order of supervision was granted. A Preventive Services Case was opened. The record did not reflect attempts to contact the father.

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:

Although ECDSS spoke with the paternal grandmother who resided with the father, the record did not reflect attempts were made to interview the father or obtain his contact information.

Legal Reference:

18 NYCRR 432.1 (o)

Action:

ECDSS will make efforts to make face-to-face contact with a child’s parents or guardians and document efforts that were unsuccessful.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

Interviews with mother and collateral contacts revealed that mother had a neurological disorder and had dropped the child in the past as a result. The record did not reflect that mother's medical provider was contacted to gather information around her illness and ability to safely care for an infant.

Legal Reference:

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

Action:

ECDSS will make efforts to contact collaterals to gather relevant information as it pertains to safety and risk.

[redacted]

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

06/02/21-08/04/21 The SM was substantiated for IG and PD/AM regarding the SSs. She was unsubstantiated for L/B/W of the eldest sibling. The BF was unsubstantiated for IG of the SSs. Another adult was unsubstantiated for IG and SA regarding the 12yo SS.

05/14/19-09/20/19 The SM was unsubstantiated for IG, PD/AM, LMC and EdN regarding the two eldest siblings.

09/19/19-10/07/19 The SM was unsubstantiated for IG regarding the two eldest siblings.

01/28/20-04/29/20 The SM was unsubstantiated for IG of the 12yo SS.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 03/11/2024

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 03/11/2024

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☐	☒	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☒	☐	☐	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☐	☒	☐	☐

Additional information, if necessary:
Services were provided by a community-based agency.

Required Action(s)

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

Issue:	Failure to Complete a Plan Amendment
Summary:	Although the child died within 60 days of the next FASP being due, the FASP was completed untimely on 10/21/24; therefore, the FASP requirement was not met as the death was not reflected in a FASP for more than 60 days.
Legal Reference:	18 NYCRR 428.7
Action:	ECDSS will complete a Plan Amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. This will be done within 30 days of the change if an initial FASP has already been completed unless the change occurs within 60 days of the next FASP. In that instance, the change can be documented at that time.

Preventive Services History

A Preventive Services Case was opened on 09/19/19 as there were concerns for the mother's ability to care for the children. A Neglect Petition was filed against the mother on 10/02/19 as there were ongoing concerns with the mother's mental health, her drug and alcohol misuse as well as domestic violence. An order of supervision was granted on 10/10/19. There was a finding of Neglect with admission on 02/25/20. The family was provided with domestic violence services and case management services. The mother was waitlisted for drug counseling and treatment. After all goals were met and the order of supervision expired on 01/21/21, the case was closed on 01/27/21.

A Preventive Services Case was opened on 03/11/24 as the child was diagnosed with a medical condition and the mother struggled to manage it. The mother was observed shaking the child while in the hospital. The mother discontinued administering the child's medication against medical advice and was overwhelmed with the treatment the child's condition required. The family was provided with case management services, drug treatment therapy, Early Intervention and mental health services. The Services case remained open at the time of this writing.

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

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
03/08/2024	There was not a fact finding	There was not a disposition
Respondent:	069538 Mother Female 36 Year(s)	
Comments:	Although the record reflected an order of supervision was granted, the record did not reflect the outcome of the petition. The activities screen did not reflect that a Petition was filed.	

Additional Local District Comments

We at the Erie County Department of Social Services appreciate the opportunity given us to review the draft response in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality.

Upon further review of the CPS investigations conducted during the three years preceding the fatality, we must unfortunately concur with the compliance issues identified relative to the SCR report dated 2/2/2024. We agree that, although efforts were made and documented to make face to face contact with the child's parents, that the efforts were minimal and insufficient. We must also agree that no efforts were documented to contact relevant collaterals that might have pertained to safety and risk. In addition, we must also concur that the plan amendment was not completed in a timely manner. As a corrective action these compliance issues have been reviewed and addressed with the assigned Team Leader. Additionally, these compliance issues are part of an ongoing Program Improvement Plan being developed in collaboration with the OCFS Buffalo Regional Office.

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