Child Fatality Report

Report Identification Number: BU-16-032

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

Issue Date: Jul 27, 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	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-Other	
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	

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 10/24/2016
Initial Date OCFS Notified: 10/24/2016

Presenting Information

"On 10/24/16 PS took sleeping pills while being the sole caretaker for the subject child, age 1 and surviving siblings age 2 months, 3 and 8 years old. The PS fell asleep and when he woke up at approximately 11:45pm he found the subject child on the bathroom floor unresponsive and deceased. It was unknown when the subject child was last seen alive. The conditions inside the home were deplorable. There were empty beer cans and bottles, and food all over the floor. In addition there were open pill bottles, household cleaners and rat poison left out and accessible to the children. It was unknown if the subject child had a preexisting medical condition that contributed to her death. The condition of the child's body was unknown. The mother was at work at the time of the subject child's death but was aware of the conditions inside of the home."

Executive Summary

This report concerns the death of a one-year-old CHD who resided with the SM, PS and surviving siblings (SS) ages eight and three-years-old and two-months-old. The children were being watched by parent substitute (PS), while SM was at work. The PS was indicated in one previous SCR report with allegations of IG, LBW's and S/D/S due to a DV incident with a previous girlfriend.

An SCR report with allegations of IFCS, IG and DOA/Fatality was received by ECDSS against PS and SM with respect to the SC and the SS's. On 10/24/16 PS took sleeping pills, while being the sole caregiver for the children. The PS fell asleep and when he woke up at approximately 11:45 PM, he found SC on the bathroom floor unresponsive and deceased. It is unknown when the child was last seen alive. The conditions inside of the home were deplorable. There were empty beer cans and food all over the floor. In addition, there were open pill bottles, household cleaners and rat poison left out and accessible to the children. It is unknown if the child had a preexisting medical condition that contributed to her death. The condition of the child's body is unknown. The mother was at work at the time of the child's death, but was aware of the conditions inside of the home. ECDSS interviewed everyone named on the report. The SM stated she was at work and was driving home, when PS called her and told her something was wrong with the SC. The SM stated that she was aware that PS had a couple drinks, but denied him being intoxicated. She stated that he takes Tylenol PM and occasional smokes weed, but denied any other drugs. She stated that he did leave the children alone for a couple of minutes to run to the corner store, but the eight-year-old is old enough to watch the children for a few minutes. The SM stated she was home for lunch around 6:30 PM and all children appeared safe. The SS gave different accounts of the day, but all confirmed that PS was drinking and went to the store for a bit. The eight-year-old SS stated PS takes smaller red and white pills that are kept in a box on the lower shelf in the bedroom, the pills are also in a bottle and there were pills on the floor. The PS was arrested for giving a false name at the scene and CW interviewed him in Jail. PS stated him and the kids just "hung out" all day and watched TV and played. He stated he had left the Tylenol PM on the table in the living room and he must not have snapped the cap all the way back on. He stated that he did take 2 pills that evening and had a couple drinks, but denied being intoxicated. He stated he laid down after SM went back to work, but only for a couple minutes. He stated he woke up and found SC unconscious in the bathroom. He stated he picked SC up and shook her and put water on her face, trying to wake her up and called 911.
The Me determined the Cause of Death was Acute Diphenhydramine and Acetaminophen Intoxication with the Manner of Death Undetermined. On December 22, 2016 ECDSS substantiated the allegations of IFCS and IG against SM and PS and DOA/Fatality and PDAM against PS with respect to the children. The home was found to be in a deplorable state with harmful substances within reach of the children; floors and counter tops were littered with various debris such as garbage and old food. Also within reach of the children were household cleaning chemicals, rat poison and OTC drugs (Tylenol PM). PS stated to police he had drunk alcohol and taken Tylenol PM and gone to

bed, leaving the children unsupervised. SM came home from work on her break and would have been aware of the deplorable state of the home. An Abuse petition was filed in Erie County Family Court on 11/2/16 and SS were placed in 1017 custody with relatives with an OOP in place against PS and supervision granted by family court. The case will remain open for services.

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 children were placed in 1017 custody with relatives and the family is working with court ordered preventive services.

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:
ECDSS substantiated the allegations against PS and SM. The CW filed an abuse petition in family court and the family is working court ordered preventive services.

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

Child Fatality Report

Date of Death: 10/24/2016 **Time of Death:** 12:02 AM

Time of fatal incident, if different than time of death: 11:45 PM

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 11:46 PM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 4 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was:

- ☒ Drug Impaired
- ☒ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	Female	1 Year(s)
Deceased Child's Household	Mother -	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Mother's Partner -	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Month(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	8 Year(s)
Other Household 1	Other Adult - Sibling's father	No Role	Male	27 Year(s)
Other Household 1	Other Adult - Sibling's father	No Role	Male	24 Year(s)

LDSS Response

The CW visited the MGM's home, spoke with family, SM and SS's. SM agreed to take the SS to the CAC for a medical exam. SM said PS watched the children when she worked. SM stopped home on her break at 6:30 and the children were fine and PS was sober. SM said that PS drinks alcohol and smokes marijuana but not to excess. She denied he was

intoxicated that day. SM was aware that PS went to the corner store. SM said that the 8yo can watch the children for a couple minutes. SM said that SS told her SC got into the pills. SM said PS takes Tylenol PM for tooth pain. SM said the pills were on the table, but PS told her some were on the floor. SM denied PS using any other drugs or that she used drugs or alcohol. SM said that PS called her at 11:45 PM and said something was wrong with SC and that he called 911. When SM got home, SC was on the couch not breathing. The CW spoke to all SS's and the 8yo SS completed an MDI. SS said PS was drinking out of a grey bottle and he went to the store to get more liquor. SS said SC took pills. SS denied seeing SC ingest any pills. She said that PS takes the pills and they are kept in the bottle in the bedroom, but they were all over the floor. The family agreed to a safety plan that the SS's would stay with family and not be alone with SM. The CW spoke with PS at the jail. PS said that SC must have gotten into the Tylenol PM and he must not have put the cap all the way back on the bottle. PS kept saying I tried to save her. PS said he was in the bedroom with the baby, because she was fussing. He said he laid down at 7:00 PM and woke up because it was "too quiet" and then found SC on the bathroom floor and called 911. PS said he drank 1 drink which was 8% alcohol and took 2 Tylenol PM. He denied being intoxicated. The PS said the home was messy because the kids trashed it. He denied any physical discipline of the children.
The CW spoke with the Senior Investigator (SI) with the ME's office. SI said that she saw several empty bottles of alcohol in the home when she went to the scene. There were full open garbage bags in the home. Dirty plates and hotdogs were scattered throughout the home along with other open food. There was also an open bag of rat poison. The SI said there were 2 bottles of Tylenol PM in the home, 1 was labeled correctly and the other had the label ripped off. One was open and on the floor and the other was at the end of couch on a table in reach of the children. The SI also said that SC's medical record noted a hospital visit on 5/13/16 for accidental poisoning-alcoholic beverage. SM denied this happened. The LDSS tried diligently to get more detail about this and was unable to. ECDSS had not received a CPS report about this incident. ECDSS filed an Abuse petition against SM and PS and the SS's were placed in 1017 custody with MGF with an OOP for the SS's against PS. The CW worked with the police and spoke with all first responders. The police investigation is open but no charges have been filed for the SC's death. The CW spoke with the doctor and the SS's school who had no concerns for their safety.
The Me determined the Cause of Death was Acute Diphenhydramine and Acetaminophen Intoxication with the Manner of Death Undetermined. On 12/22/16 ECDSS sub the allegations of IFCS and IG against SM and PS and DOA/Fatality and PDAM against PS for the children. The home was found to be in a deplorable state with multiple harmful substances within reach of the children; littered with debris such as garbage and old food. In reach of the children were cleaning chemicals, rat poison and OTC drugs (Tylenol PM). PS told police he had drunk alcohol and taken Tylenol PM and gone to bed, leaving the children unsupervised. SM came home from work on her break and was aware of the state of the home. An Abuse petition was filed, and SS were placed in 1017 custody with relatives with an OOP in place against PS and supervision granted by family court. The case remains open for services.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: ECDSS does not have an approved CFRT.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation

			Outcome
039307 - Deceased Child, Female, 1 Yrs	039309 - Mother's Partner, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
039307 - Deceased Child, Female, 1 Yrs	039308 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
039307 - Deceased Child, Female, 1 Yrs	039308 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
039307 - Deceased Child, Female, 1 Yrs	039309 - Mother's Partner, Male, 27 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
039307 - Deceased Child, Female, 1 Yrs	039309 - Mother's Partner, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
039307 - Deceased Child, Female, 1 Yrs	039309 - Mother's Partner, Male, 27 Year(s)	DOA / Fatality	Substantiated
039310 - Sibling, Female, 8 Year(s)	039309 - Mother's Partner, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
039310 - Sibling, Female, 8 Year(s)	039308 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
039310 - Sibling, Female, 8 Year(s)	039308 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
039310 - Sibling, Female, 8 Year(s)	039309 - Mother's Partner, Male, 27 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
039310 - Sibling, Female, 8 Year(s)	039309 - Mother's Partner, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
039311 - Sibling, Female, 3 Year(s)	039309 - Mother's Partner, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
039311 - Sibling, Female, 3 Year(s)	039309 - Mother's Partner, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
039311 - Sibling, Female, 3 Year(s)	039308 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
039311 - Sibling, Female, 3 Year(s)	039308 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
039311 - Sibling, Female, 3 Year(s)	039309 - Mother's Partner, Male, 27 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
039312 - Sibling, Female, 2 Month(s)	039309 - Mother's Partner, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
039312 - Sibling, Female, 2 Month(s)	039308 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
039312 - Sibling, Female, 2 Month(s)	039308 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
039312 - Sibling, Female, 2 Month(s)	039309 - Mother's Partner, Male, 27 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
039312 - Sibling, Female, 2 Month(s)	039309 - Mother's Partner, Male, 27 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐
Daycare Provider	☐	☐	☐	☒
Other	☐	☐	☐	☒
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

ECDSS observed the home and interviewed, family members, SM, PS and surviving sibling. ECDSS worked closing with the ME's office and police, they spoke to all appropriate collaterals.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐
Explain as necessary: Children were placed in 1017 custody with MGF.				

Legal Activity Related to the Fatality

Was there legal activity as a result of 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:**
11/02/2016	Adjudicated Neglected	Order of Supervision
Respondent:	039308 Mother Female 23 Year(s)	
Comments:	SM admitted to neglect in Erie County Family Court on 6/7/2017 and signed a court menu for services.	

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/02/2016	Adjudicated Abused	Order of Supervision
Respondent:	039309 Mother's Partner Male 27 Year(s)	
Comments:	The PS did not attend any court appearances and on 6/7/2017 the Court issued an immediate default finding of abuse and severe abuse against the PS and an Order of Protection to stay away from the SS until their 18th birthdays.	

Have any Orders of Protection been issued? Yes	
From: 11/02/2016	**To:** 08/30/2034
Explain: PS is to stay away from any contact with SS until their 18th birthdays.	

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:
ECDSS provided the family with court ordered preventive services. ECDSS spoke with all appropriate collateral contacts.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
Children were placed in 1017 custody with MGF.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:

ECDSS filed an abuse petition in family court. The family began working with court ordered preventive services and the children were placed in 1017 custody with MGF.

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

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)
05/14/2015	Sibling, Female, 2 Years	Mother, Female, 22 Years	Lack of Supervision	Unfounded	Yes

Report Summary:
On 5/14/15 SM failed to adequately supervise the then two-year-old SS. As a result, the child was outside alone and unsupervised for 25 minutes without SM being aware she was missing. The SS did not sustain any injuries. The role of siblings are unknown.

The SM and other adults were in the home packing for a vacation. SM thought all of the children had gone on a walk with one of the other adults. When the other adults returned they discovered SS was not with them and was missing.

Determination: Unfounded | **Date of Determination:** 03/31/2016

Basis for Determination:
Child was found by neighbors unsupervised outside. SM thought another adult was with the child and it appears that there was a miscommunication between family members. No arrest or police report was made. Family members report that the children are usually well supervised by mother. Appropriate supervision discussed with all parties. SM had since moved out on her own and the home is very minimal. Referral made to Salvation Army, SM given pack-n-play. CPS intervention no longer necessary. Children appeared safe at that time.

OCFS Review Results:
ECDSS observed the homes the family was living in. The home was minimally furnished but safe for the family to reside and ECDSS did assist with a referral and obtaining appropriate sleeping arrangements. The CW spoke with appropriate collateral contacts and interviewed everyone residing in the home. ECDSS observed the children on 5/19/15 and did not see the children again until 1/22/16.

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

Issue:
Adequacy of Child Protective Services casework contacts

Summary:
There was an 8 month gap between the CW seeing the children. ECDSS observed the children and assess their safety on 5/18/15 and 5/19/15. ECDSS attempted home visits with no contact with the family on 11/17/15 and 12/5/15. ECDSS did

not see the children until 1/22/16.

Legal Reference:

432.2(b)(4)(vi)

Action:

ECDSS must assess children's safety on a regular basis during the life of the case. This issue has been addressed with ECDSS in previous instances throughout the same timeframe of when this gap in contacts occurred in this case. ECDSS must review their previous plan to address this issue and revise their plan as necessary and appropriate.

[redacted]

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

PS was indicated in 2012 with allegations of IG, LBW's and S/D/S during a domestic violence incident where his child was injured.

Known CPS History Outside of NYS

No known CPS history outside NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☐Yes ☒No

Preventive Services History

ECDSS opened a court ordered preventive services case with the family on 10/26/16 after the SC's death. The home was found to be unsafe for the family to reside in. There was open rat poison in the home accessible to the children, open food, garbage and liquor bottles scattered throughout the home. The SM was aware that the PS was drinking and taking Tylenol PM and still allowed him to babysit the children. The SM did not understand the concerns with the home or the supervision of the children. ECDSS filed an abuse petition in Erie County Family Court and the children were placed in 1017 custody with relatives with an OOP against the PS. Services have linked the SS to grief counseling. SM is ordered to attend counseling, parenting classes, supervised visitation, have appropriate housing and income to support her family. The family continues to work with services.

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. We unfortunately concur with the reviewer's finding that one of the cases in the past history dated May 14, 2015 had a gap in contact with the alleged maltreated children. This investigation occurred at a time of very high caseloads at the county, which at times impacted the caseworkers' ability to make contact with families in accordance with best case practices. This issue has been addressed in past Program Improvement Plans and is an issue that is regularly and consistently addressed with all staff. Caseworkers and Team Leaders are frequently reminded about the importance of contacts being up to date, and staff are held accountable appropriately when there are gaps in contact. Through our concerted efforts in recent years to improve our practice and overcome a multiyear crisis involving high caseloads, we are striving to make such gaps in contact a thing of

the past here at Erie County. 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