

Report Identification Number: BU-18-021

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

Issue Date: Nov 30, 2018

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 <u>only</u> 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			
DrDoctor	ME-Medical Examiner	EMS-Emergency Medical Services			
DC-Day Care	FD-Fire Department	BM-Biological Mother			
CPS-Child Protective Services					
	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	ACS-Administration for Children's	NYPD-New York City Police			
Service	Services	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	<u> </u>				



Case Information

Report Type: Child Deceased **Jurisdiction:** Erie **Date of Death:** 07/17/2018

Age: 2 year(s) Gender: Male Initial Date OCFS Notified: 07/17/2018

Presenting Information

An SCR report alleged on 7/17/18, while in the care of his mother and the father of his siblings, the 2-year-old SC sustained an unknown injury causing cardiac arrest, which resulted in his death. The SC was brought to the hospital by EMS after a call was received from the SM between 2:30 and 3PM. EMS found the SC in cardiac arrest at the home. EMS brought the SC into the emergency room around 3:30PM. The suspicious death, along with an inconsistent explanation, made the SM and the siblings' father alleged subjects. The roles of the siblings were unknown. The report noted the SM told EMS the SC fell down the stairs, but she told emergency room staff he fell and hit his head on the stove and was fine, but collapsed 15 minutes later. The adults and all children were in the home during the incident. The SC had no previous medical issues and was otherwise healthy.

Executive Summary

On 7/17/18, Erie County Department of Social Services (ECDSS) received and responded to an SCR report regarding the death of a 2-year-old child. The child's mother and PS, who was the father of the two siblings, were the alleged subjects. There were inconsistent and varying explanations for what caused the SC's extensive injuries and subsequent death.

ECDSS and LE conducted separate interviews of the parents. While the mother initially denied to ECDSS that anything happened to cause injury to the child aside from him accidentally hitting his head on the stove, the PS made admissions to police. The PS admitted to shaking and beating the child. Eventually, the mother admitted she partook in physically disciplining the child, and was also aware of the PS's physical discipline toward him. The mother told police she and the PS took turns hitting the child that day, and said she was the last to hit the child before he hit his head on the stove. Though the criminal judicial proceedings were ongoing, both parents were charged with murder, manslaughter, and depraved indifference murder of a child. Both remained incarcerated at the time this report was written.

The PS called 911 when the SC became limp and unresponsive. First responders who arrived at the home attempted to resuscitate the child. Initially CPR was successful, though during transfer to the hospital, the child had no pulse and CPR was started again. Though his pulse was obtained again once they arrived at the hospital, the SC was eventually declared deceased at 3:46PM.

According to medical documentation, the SC presented at the hospital with 36 bruises on his head, 45 bruises on his torso, bruises on his wrists, and internal bruising on his liver, kidneys, intestines, and adrenal gland. The SC had healing rib fractures, and was also observed to have a large quarter-inch scar next to his eye and a half-inch scar on his cheek. The ME identified the bruises appeared to be of the same age, and the rib fractures were identified to have been sustained prior to the fatal incident. The forensic anthropologist spoke to the age of the rib fractures, which was from 1 week to 1 month prior to fatality. The ME relayed to ECDSS the cause of death was "multiple blunt force injuries," and the manner of death on the autopsy report was listed as homicide.

ECDSS arranged for the 2 surviving siblings, ages 2 months and 12 months, to be medically evaluated at the hospital on the date of the report. Both presented without acute concerns and their skeletal surveys were unremarkable. From the time a safety plan was initiated (at the onset of the investigation) and continuing through the parents' incarceration, the two siblings were cared for by their paternal great-grandmother.

ECDSS filed derivative severe abuse petitions against the parents regarding the two surviving siblings. On 7/20/18, the



Family Court Judge issued a 1017 placement with the siblings' paternal great-grandmother, with a temporary stay-away order of protection in place except for supervised visitation by the Department; however, visitation did not take place while the parents were incarcerated due to their own criminal visitation restrictions.

Given the evidence that was gathered, ECDSS appropriately indicated the report against the SC's mother and PS, holding both parents responsible for the severe injuries and subsequent death of the child. Though ECDSS took appropriate protective actions regarding the two surviving siblings, there were no allegations added against the parents regarding them; therefore, there is now no indicated CPS report on record regarding the siblings. Despite this, a Foster Care Services case remained open at the time this report was written to continue the protection, care, and services for the two young surviving children.

PIP Requirement

For the one citation noted, ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) 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:

O Approved Initial Safety Assessment? Yes

Safety assessment due at the time of determination? Yes

• Was the safety decision on the approved Initial Safety Assessment Yes appropriate?

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 Yes appropriate?

Explain:

Sufficient information was gathered to determine the allegations in the SCR report, as well as for concerns regarding the surviving siblings; however, ECDSS did not add and substantiate allegations regarding the siblings, despite the fact that severe abuse petitions were filed against the parents and the children were removed from their custody due to the concerns discovered in the investigation.

Was the decision to close the case appropriate?

N/A

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

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Total number of deaths at incident event:

Adults: 0

Children ages 0-18: 1

Child Fatality Report

Was there sufficient documentation of supervisory consultation?

Yes, the case record has detail of the consultation.

Explain:

The decision to close the CPS investigation was appropriate. A case was then opened to address service needs for the two siblings who entered placement as a result of the fatality.

C	ı	
	Required Actions Related to the Fatality	
A wa thawa Daguiya	d Actions related to the compliance issue(s)? Myes No	
Are there Required Issue:	d Actions related to the compliance issue(s)?	
issue:		1 /
Summary:	Though ECDSS took appropriate protective actions for the S abuse petitions) no allegations were added for the siblings; he to indicate they were maltreated by the parents.	· ·
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)	
Action:	ECDSS will reflect the investigative work that was complete when necessary in order to make a determination of the nature condition identified during the investigation that may constitute.	re, extent and cause of any other
	Fatality-Related Information and Investigative	e Activities
	Incident Information	
Date of Death: 07/	17/2018 Time of Death: 03:4	16 PM
Time of fatal incid	ent, if different than time of death:	Unknown
County where fata	lity incident occurred:	Erie
•	mergency number called?	Yes
Time of Call:	g ·	02:41 PM
Did EMS 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☐ Other	Eating	Unknown
-	ervision at time of incident leading to death? Yes supervisor was: Not impaired.	

Household Composition at time of Fatality

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Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Month(s)
Other Household 1	Father	No Role	Male	29 Year(s)

LDSS Response

ECDSS immediately responded to the SCR report by contacting the source, District Attorney, LE, family, and hospital staff. ECDSS prioritized arranging a medical assessment of the 2 SS at the hospital. ECDSS learned both SS were medically well, and further assessed their safety by visiting the home of their PGGM and interviewing her and their paternal aunt. A safety plan was devised whereby the PGGM would not allow either parent contact with the children. ECDSS ensured the children had safe sleeping arrangements and discussed safe sleep with the relatives; a portable crib was provided.

The SM gave varying accounts of the timeline leading up to the fatality. Initially, she denied anything happened to the SC aside from him running into the stove. LE relayed that the SM admitted to them that she and PS hit the SC. She stated she and PS would typically take turns hitting him, to equally share the discipline. She stated she was the last one to hit the child. Later, once incarcerated, she told ECDSS she saw the PS spank the SC for taking his diaper off in the crib, and said when she returned from the store after being gone from approximately 11AM to 12PM, she observed a bruise on the SC's cheek, learning from the PS that he "whooped" him for spitting out food. SM said she hit the SC on the leg a few times with a slipper, then once on the head. She said she told him to come to her as she was trying to feed him, which was when he hit his head on the stove. Regarding the old rib fractures, the SM only offered the explanation that the PS spanked the SC about 1 month ago with a slipper on his buttocks and legs.

LE relayed PS admitted to causing the injuries which lead to the SC's death. ECDSS interviewed the PS while incarcerated. He stated he and SM physically disciplined the SC in "extreme situations." The PS reported around 5 or 6:00AM, he awoke to the middle child screaming, and saw the SC with his diaper off and his tongue in her mouth. He stated he grabbed the SC and shook him out of anger. He then lifted the SC by both wrists with one hand while he hit him with the other hand about 10 times. He then went back into the bedroom and the mother came out to discipline him. He could hear SM yelling at and spanking the SC. He reported when the SM left for the store at 11AM, he put the SC in time out. Later, the SC jumped off the landing by the stairs, falling face first. He said the SC did not appear injured, but he noticed bruising on his forehead. He then hit the SC on the hand when the SC jumped on his sister in her car seat. He said the SC ran and hit his head on the stove just prior to SM returning home. Then about 10 minutes later, he noticed SC's chest was not moving, and he heard no heartbeat. He took the SC into the living room, started CPR, and called 911. The PS reported he lied to police by admitting to causing the injuries so that he could take the blame, so his daughters would have their mother remain as caretaker.

ECDSS reviewed all medical documentation and spoke with the ME. Medical professionals spoke to the fact that the descriptions did not sufficiently explain the child's condition. From the pediatrician, ECDSS learned the SC and the middle child were diagnosed failure to thrive. Interventions and further assessments were being implemented for the SC's difficulties with language and coordination. The SC was last seen by the pediatrician on 7/12/18, and when ECDSS spoke with the Dr. who saw the child, there was no note of injuries nor other concerns, as the parents were reportedly following through with the care plan.

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According to a resource, the SC's father was incarcerated out of state at the time of the fatality. ECDSS attempted to verify this and attempted contact, but was unsuccessful.

Following the siblings' placement, Family Court action was ongoing. After the investigation closed, ECDSS continued to provide services to the family in their open case.

Official Manner and Cause of Death

Official Manner: Homicide

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: There is no OCFS approved Child Fatality Review Team in Erie County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047505 - Deceased Child, Male, 2 Yrs	047507 - Mother's Partner, Male, 23 Year(s)	DOA / Fatality	Substantiated
1		Inadequate Guardianship	Substantiated
047505 - Deceased Child, Male, 2 Yrs	047506 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
047505 - Deceased Child, Male, 2 Yrs	· · ·	Inadequate Guardianship	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?		\boxtimes		
Contact with source?	\boxtimes			
All appropriate Collaterals contacted?	\boxtimes			
Was a death-scene investigation performed?	\boxtimes			

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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?	\boxtimes			
Was there timely entry of progress notes and other required documentation?				
Additional information:	•	•	•	•
Efforts were made to interview the subject child's biological father, but contact	was unab	ole to be m	ade.	
Fatality Safety Assessment Activities				
				l
	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 shousehold named in the report:	surviving	siblings/c	other child	dren in the
Within 24 hours?	\boxtimes			
At 7 days?	\boxtimes			
At 30 days?	\boxtimes			
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			
Fatanty Risk Assessment / Risk Assessment	1 TOILC			
	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	\square			
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?	\boxtimes			
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				

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07/18/2018

Parent Substitute (SS's father)

Child Fatality Report

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				\boxtimes			
	me during this fatality investigation						
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?							
If Yes, court	ordered?			\boxtimes			
	cessary: ere arrested in connection to the fata under Family Court Act 1017.	ality, and the	SS were placed	in the cus	tody of the	eir patern	al great-
	Legal A	Activity Relate	ed to the Fatality				
⊠Family Cou	al activity as a result of the fatality rt	nal Court	on?	⊠Ord	er of Prote	ction	
Date Filed:	T T	T T	Descriptions				
	Fact Finding Description:	-	Description:		Dalatina (A	1. مانات	`
07/20/2018	There was not a fact finding	1	ody to/or Continu	uea with	Relative (A	Article 10)
	047507 Mother's Partner Male 23	. ,	.1 1	. 1	1	C 11 :	.1
Comments:	After severe abuse petitions were fincarceration of both adults, the tw great-grandmother on 7/20/18 under	o surviving s	iblings were pla	ced into the	he custody	of their p	paternal
Family Cour	t Petition Type: FCA Article 10 - C	CPS					
Date Filed:	Fact Finding Description:	Disposition	Description:				
07/20/2018	There was not a fact finding	Direct Custo	ody to/or Continu	ued with	Relative (A	Article 10)
Respondent:	047506 Mother Female 22 Year(s)						
Comments:	After severe abuse petitions were filed against the mother and parent substitute, and following the incarceration of both adults, the two surviving siblings were placed into the custody of their paternal great-grandmother on 7/20/18 under the Family Court Act 1017. The court process remained ongoing.						
Criminal Ch	arge: Manslaughter Degree: 1						
Date Charges Filed:	Against Whom?		Date of Disposi	ition:		Disposit	ion:

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Pending

Pending



Comments:	In connection to the subject child's death, the parent substitute was charged with manslaughter. The case
	was being heard in front of the Grand Jury, and criminal court proceedings were ongoing.
	•

Criminal Charge: Manslaughter Degree: 1					
Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:		
07/19/2018	Subject Mother	Pending	Pending		
	In connection to the subject child's death, the child's mother was charged with manslaughter. The case was being heard in front of the Grand Jury, and criminal court proceedings were ongoing.				

Criminal Charge: Murder Degree: 2					
Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:		
07/18/2018	Parent Substitute (SS's father)	Pending	Pending		
Comments:	In connection to the subject child's death, the parent substitute was charged with murder. The case was being heard in front of the Grand Jury, and criminal court proceedings were ongoing.				

Criminal Charge: Murder Degree: 2					
Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:		
07/19/2018	Subject Mother	Pending	Pending		
	In connection to the subject child's death, the child's mother was charged with murder. The case was being heard in front of the Grand Jury, and criminal court proceedings were ongoing.				

Criminal Charge: Other - Depraved indifference murder, subdivision 4 Degree: NA				
Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:	
07/18/2018	Parent Substitute (SS's father)	Pending	Pending	
	In connection to the subject child's death, the parent substitute was charged with depraved indifference murder of a child. The case was being heard in front of the Grand Jury, and criminal court proceedings were ongoing.			

Criminal Charge: Other - Depraved indifference murder, subdivision 4 Degree: NA			
Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
07/19/2018	Subject Mother	Pending	Pending

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In connection to the subject child's death, the child's mother was charged with depraved indifference murder of a child. The case was being heard in front of the Grand Jury, and criminal court proceedings were ongoing.

Have any Orders of Protection been issued? Yes	
From: 07/20/2018	To: Unknown
Explain:	

Temporary orders of protection were issued against the mother and the parent substitute regarding the two surviving siblings, following a severe abuse petition filed against both parents in response to the fatality. It was ordered they have no contact with the children, except for supervised visitation, supervised by ECDSS.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling							
Economic support							
Funeral arrangements				\boxtimes			
Housing assistance							
Mental health services				\boxtimes			
Foster care	\boxtimes						
Health care	\boxtimes						
Legal services	\boxtimes						
Family planning				\boxtimes			
Homemaking Services				\boxtimes			
Parenting Skills				\boxtimes			
Domestic Violence Services				\boxtimes			
Early Intervention				\boxtimes			
Alcohol/Substance abuse							
Child Care							
Intensive case management						\boxtimes	
Family or others as safety resources							
Other							

Additional information, if necessary:

Some services were not able to be offered to the parents as they were incarcerated during the majority of the investigation, but many were planned. Services were provided to the SS and their caregiver, and the case remained open.



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

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There is only one historical case more than 3 years prior to the fatality, and it concerns the parent substitute. A report dated 5/6/14 was indicated against him and 2 other adults for inadequate guardianship and inadequate food/clothing/shelter concerning his 2 nephews.

Known CPS History Outside of NYS

ECDSS contacted CPS in the state of Maryland, where the PS used to reside, and learned he had no CPS history there. ECDSS contacted CPS in the state of Virginia, where the SM and SC used to reside with the SC's biological father. There was one record of a case regarding domestic violence, whereby the SC's father attempted to strangle the mother in front of the child. It was noted the mother and child left the area and the father was arrested, though there was no mention of whether a report was indicated or unfounded.

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

While ECDSS appreciates the reviewer's recognition that we took appropriate actions to protect the surviving siblings by effecting a removal and filing severe abuse petitions, we agree that allegations regarding said siblings should have been added to the SCR report. However, we note that the suggestion of adding allegations was not brought up by OCFS during our 45-day conference with OCFS, and we invite OCFS to bring up any suggestions during said conferences in the future. In response to the citation, ECDSS will remind all workers and supervisors investigating fatalities to review all information to ascertain whether information collected during the investigation warrants any additional abuse or neglect allegations. If such allegations are warranted, they will be added to the report. This process will be monitored through



supervisory conferences and reviews conducted by the ECDSS Coordinator who oversees the child fatality teams, as well as through 45-day conferences with OCFS staff.

	Recommended Action(s)
1	Are there any recommended actions for local or state administrative or policy changes? Yes No
4	Are there any recommended prevention activities resulting from the review? Yes No