Child Fatality Report

Report Identification Number: BU-19-020

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

Issue Date: Oct 18, 2019

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	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		
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	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 05/26/2019
Initial Date OCFS Notified: 05/26/2019

Presenting Information

An SCR report alleged the children were involved in a serious two-car accident. The children were not restrained in seatbelts or booster-seats and were ejected from the car. All of the children sustained internal injuries and lacerations. The children (aged 6 and 10 years) had emergency operations and were in critical condition. The child (aged 4 years) was in the emergency room, awake and in stable condition. The mother and father did not have the children restrained, placing them in harm's way.

Executive Summary

This fatality report concerns the death of the 4-year-old female subject child who died on 5/26/19. An SCR report received on the same day concerned a motor vehicle accident which resulted in the occupants being ejected from the vehicle, landing on the roadway and surrounding grassy areas. The children were not in proper car restraints. Subsequent reports were received on 5/26/19 and on 6/10/19 regarding the subject child's death. It was also reported her 4-year-old cousin died as a result of the accident; however, she survived the crash. The mother and maternal grandmother were pronounced deceased on scene. The surviving children, a 14-year-old sibling, and three cousins (aged 4 and 10 years) were assessed to be safe in the care of their family.

All vehicle occupants were family members who resided together in New Jersey and were visiting New York at the time of the accident, which took place in Wyoming County. The surviving family members were in Erie County at the time the SCR report was made.

Erie County Department of Social Services (ECDSS) coordinated investigative efforts with law enforcement upon receipt of the initial report. ECDSS contacted Wyoming County, where the accident took place, and Monroe County, where the deceased were transported for autopsies. Autopsies were performed; however, Monroe County's District Attorney would not provide Erie County with the child's autopsy report.

EMS responded and performed lifesaving measures on the child as she was transported to the hospital, where she succumbed to her injuries and was pronounced deceased.

On 5/26/19, ECDSS visited the family at the hospital. The maternal grandfather was adamant the children were restrained in booster-seats at the time of the accident. The 14-year-old sibling was in the front passenger seat, wearing a seatbelt. He remembered a car ran through a stop sign and collided with his family's SUV, and he and the cousins were transported to the hospital. The other surviving family members were observed, but could not be interviewed due to their medical statuses.

The surviving family members were interviewed and assessed throughout the investigation. ECDSS contacted Child Protective Services in New Jersey, who assessed the children to be safe when the family returned home. Multiple collateral contacts were made and did not have concerns for the safety of the surviving children.

ECDSS contacted multiple community-based resources and provided the family with clothing vouchers, travel expenses, grief and mental health counseling, and funeral assistance. ECDSS reached out to New Jersey so the family would be connected with the resources when they returned home. The family was engaged in services through Middlesex County, New Jersey at the time of case closure.

ECDSS conducted a thorough investigation and completed the required Safety Assessments and 24-hour and 30-day Fatality Summary Reports timely. The Safety Assessments were completed inaccurately. Written notice of existence of the SCR reports was not provided to all adults timely. ECDSS did not add the allegations of Internal Injuries and L/B/W to the fatality investigation, despite information obtained during the investigation. These allegations were substantiated against the adults regarding the children excluding Internal Injuries for the 14-year-old sibling in the initial report. The allegations against the adults regarding the death of the cousin were appropriately unsubstantiated. The adults were substantiated for the Inadequate Guardianship of the children as the children, with the exception of the 14-year-old sibling, were not properly restrained in the family's SUV.

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

Was the decision to close the case appropriate? Yes

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

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

Explain:

The case was appropriately closed after the family was connected to services in their home state of New Jersey.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Multiple progress notes were not entered contemporaneously during the investigation and were documented 8 weeks after the event dates.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.
Issue:	Failure to provide notice of report
Summary:	Regarding the fatal incident, the adults were provided written notice 50 days late. The father was not provided written notice regarding the death. The adults were not provided written notice regarding the subsequent report received on 6/10/19.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ECDSS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report. ECDSS will make diligent efforts to contact absent parents of children named in a report and to provide written notice within 7 days of receipt of the report.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The Safety Assessments were completed timely but inaccurately. Some of the Safety Assessments noted concerns for supervision that were not noted in the case record and did not include the caregivers' unwillingness/inability to protect the children.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances with regard to safety.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/26/2019 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Wyoming
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 2

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	55 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	47 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Other Child - Cousin	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Other Child - Cousin	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Other Child - Cousin	Alleged Victim	Female	10 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	14 Year(s)
Other Household 1	Father	No Role	Male	37 Year(s)
Other Household 2	Other Adult - BF of Cousins	No Role	Male	34 Year(s)
Other Household 3	Other Adult - BF of Sibling	No Role	Male	34 Year(s)

LDSS Response

On 5/26/19, ECDSS received an SCR report regarding a motor vehicle accident which resulted in the occupants being ejected from the SUV. ECDSS immediately initiated their investigation by contacting law enforcement. ECDSS notified the medical examiner and District Attorney's office of the death within the first 24-hours of the investigation. A New York State CPS history check was documented, which returned no results. A subsequent report was received on the same day which alleged the 4-year-old twin cousins were killed in the crash.

On 5/26/19, ECDSS observed some family members in serious medical conditions, and briefly spoke with others. The maternal grandfather said he was in the SUV in the second row next to the maternal grandmother and a 4-year-old cousin. The mother was driving and the sibling was in the front passenger seat. The aunt and two other children were in the third row. The grandfather insisted the children were in proper restraints and car seats; however, no car seats were located.

The sibling saw another vehicle speeding through a stop sign and could not remember anything after the accident other than being transported to the hospital via ambulance. He thought everyone had their seatbelts on and that his family members were sober.

A hospital nurse said the twin cousins were alive, but a 4-year-old, the subject child, died because of the crash. The mother and grandmother were also killed. One of the twins was in critical condition and was unlikely to walk or talk again.

On 5/28/19, ECDSS saw some family members at the hospital alongside law enforcement, who reported no car seats were located on scene. The aunt said the car seats were in New Jersey. The family was distraught and agreed to be interviewed the following day.

On 5/29/19, the aunt was interviewed. She said the mother and sibling were in the front row, the grandparents in the second and four children were in the third row. The twins were sharing one seatbelt. The family was unable to continue the interview, and were provided information for grief counseling. The grandfather again insisted the children were in booster seats, but said the younger children were in the third row.

Law Enforcement said they were called to the scene of the accident, where there were bodies lying in the roadway and the SUV was positioned on its side, in a ditch; there were nine people in a seven-passenger vehicle. The driver of the other vehicle was intoxicated at the time of the accident as evidenced by glassy eyes and slurred speech. He was subsequently arrested for Driving While Intoxicated, Reckless Driving, and Reckless Vehicular Homicide. He was awaiting trial at the time this report was written.

The family returned home to New Jersey, where local CPS assessed them in their home. There were no concerns for the family, and they were offered and accepted grief counseling. The less-affected twin was interviewed and said she was sitting on the aunt's lap and was not wearing a seatbelt. The 10-year-old cousin said the other children shared a seatbelt. The sibling chose not to speak further about the accident.

On 7/11/19, ECDSS obtained some contact information regarding the fathers of the surviving children. There was no information for the father of the sibling. The father of the cousins was predeceased. On 7/23/19, a phone call was made to the father of the subject child, to no avail.

ECDSS made multiple collateral contacts and gathered information from first responders. First responders reported the subject child was secreting frothy blood from her nose, and they rubbed her sternum and talked at her while she was transported to the hospital. First reports said the less-affected twin told EMS she was not wearing a seatbelt riding in the front seat, and did not know her name. Extended family members were interviewed, and had no concerns for the surviving children.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
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 reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The death was referred to the CFRT during the course of the investigation.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051160 - Deceased Child, Female, 4 Yrs	051171 - Aunt/Uncle, Female, 26 Year(s)	DOA / Fatality	Substantiated
051160 - Deceased Child, Female, 4 Yrs	051170 - Grandparent, Female, 47 Year(s)	DOA / Fatality	Substantiated

051160 - Deceased Child, Female, 4 Yrs	051171 - Aunt/Uncle, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
051160 - Deceased Child, Female, 4 Yrs	051169 - Grandparent, Male, 55 Year(s)	Inadequate Guardianship	Substantiated
051160 - Deceased Child, Female, 4 Yrs	051170 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Substantiated
051160 - Deceased Child, Female, 4 Yrs	051168 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
051160 - Deceased Child, Female, 4 Yrs	051169 - Grandparent, Male, 55 Year(s)	DOA / Fatality	Substantiated
051164 - Other Child - Cousin, Female, 10 Year(s)	051168 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
051164 - Other Child - Cousin, Female, 10 Year(s)	051169 - Grandparent, Male, 55 Year(s)	Inadequate Guardianship	Substantiated
051164 - Other Child - Cousin, Female, 10 Year(s)	051171 - Aunt/Uncle, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
051164 - Other Child - Cousin, Female, 10 Year(s)	051170 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Substantiated
051165 - Other Child - Cousin, Female, 4 Year(s)	051171 - Aunt/Uncle, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
051165 - Other Child - Cousin, Female, 4 Year(s)	051171 - Aunt/Uncle, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
051165 - Other Child - Cousin, Female, 4 Year(s)	051168 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
051165 - Other Child - Cousin, Female, 4 Year(s)	051170 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Substantiated
051165 - Other Child - Cousin, Female, 4 Year(s)	051169 - Grandparent, Male, 55 Year(s)	Inadequate Guardianship	Substantiated
051165 - Other Child - Cousin, Female, 4 Year(s)	051170 - Grandparent, Female, 47 Year(s)	DOA / Fatality	Unsubstantiated
051165 - Other Child - Cousin, Female, 4 Year(s)	051169 - Grandparent, Male, 55 Year(s)	DOA / Fatality	Unsubstantiated
051166 - Other Child - Cousin, Female, 4 Year(s)	051168 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
051166 - Other Child - Cousin, Female, 4 Year(s)	051169 - Grandparent, Male, 55 Year(s)	Inadequate Guardianship	Substantiated
051166 - Other Child - Cousin, Female, 4 Year(s)	051170 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Substantiated
051166 - Other Child - Cousin, Female, 4 Year(s)	051171 - Aunt/Uncle, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
051167 - Sibling, Male, 14 Year(s)	051169 - Grandparent, Male, 55 Year(s)	Inadequate Guardianship	Substantiated
051167 - Sibling, Male, 14 Year(s)	051170 - Grandparent, Female, 47 Year(s)	Inadequate Guardianship	Substantiated
051167 - Sibling, Male, 14 Year(s)	051168 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated

051167 - Sibling, Male, 14 Year(s)	051171 - Aunt/Uncle, Female, 26 Year(s)	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?	☒	☐	☐	☐
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?	☐	☒	☐	☐

Additional information:

Some subjects of the report, including the maternal grandmother and aunt, were not interviewed as they were killed as a result of the accident.

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	☒	☐	☐	☐

Explain:
The family was provided with services including burial assistance, financial assistance, The Ronald McDonald House, and assisted with obtaining health insurance and transportation allowances.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Explain as necessary:
The investigation did not reveal concerns that would result in the removal of a child.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐ Family Court ☒ Criminal Court ☐ Order of Protection

Criminal Charge: Other - DWI, Reckless Driving, Reckless Vehicular Homicide		**Degree:** NA	
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	At-fault Driver	Pending	Pending
Comments:	The at-fault driver was arrested for Driving While Intoxicated, Reckless Driving, and Reckless Vehicular Homicide.		

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	☒	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☒	☐

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:
The sibling and other children were offered bereavement and grief counseling services. The family relocated home to New Jersey where the services were continued.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The aunt and grandfather were provided with information regarding burial assistance, grief and mental health counseling. The family was referred to the Ronald McDonald House, where they resided until they traveled back to New Jersey.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	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 was no known New York State CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

A report was made to the Child Protective Service in New Jersey on 6/26/15. There was an allegation the mother and father engaged in physical domestic violence in the presence of the child. The father was arrested for assault, but it was later determined the mother embellished the incident. The allegations of neglect, which in the state of New Jersey are defined as "substantial risk of physical injury/environment injurious to health and welfare" were not established.

On 10/5/15, a report was made to the Child Protective Service in New Jersey. The report alleged the mother was making suicidal threats, stating she was going to jump off of a bridge. The findings in the case were not established to have had a substantial risk of physical injury/environment injurious to health and welfare.

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) appreciate the opportunity given us to review the draft report in advance. Upon consideration of the three identified Required Actions related to the compliance issues, we make the following observations: First, we must unfortunately concur with the reviewer that there were multiple progress notes documented eight weeks after the event dates. We do note, however, that these make up a small fraction of the voluminous number of progress notes, the vast majority of which were entered in a very timely manner. We also point out that all notes identified as not having been entered in a contemporaneous manner documented the content of medical or law enforcement records which were requested and obtained early on in the investigation. The original records were placed in the case file and were part of the decision-making process throughout the investigation, despite not having been added to the progress notes until several weeks after procurement. Second, we must unfortunately concur with the reviewer's

findings that required notification letters regarding the fatal incident were either mailed several weeks late or not at all. The issue of timely notification letters is being addressed as part of a consolidated Program Improvement Plan (PIP) currently being developed by ECDSS and the Buffalo Regional Office of OCFS. Finally, we respectfully disagree with the reviewer's findings that the safety assessments were completed inaccurately. We find that appropriate supervision of a child in a moving automotive vehicle includes properly restraining the child with age-appropriate car seats, booster seats and/or seatbelts. This was not accomplished in this case, as was clearly documented in the case record, and it is our contention that it was therefore appropriate to note Lack of Supervision as a safety factor in the safety assessments.

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