Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-22-001

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

Issue Date: Jun 16, 2022

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 6 year(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 01/02/2022
Initial Date OCFS Notified: 01/02/2022

Presenting Information

Erie County Department of Social Services (ECDSS) received an SCR report on 1/2/2022 which alleged that on 1/1/2022, the 6-year-old child (SC) had issues with asthma throughout the day. The mother (SM) gave the child prescribed medication to treat the symptoms. Over a 24-hour period, the child's condition worsened, and the mother did not seek medical attention. A call was made to 911 on 1/2/2022 at approximately 12:15 AM when the child stopped breathing. Emergency Medical Services responded to the home and transported the child to the hospital where he was pronounced dead at 1:03 AM. The report alleged the delay in medical attention contributed to the child's death. A second SCR report was received on 3/17/2022 which alleged the mother was under the influence of illicit substances at the time of the child's death.

Executive Summary

This report concerns the death of a 6-year-old child which occurred while in the care of his mother. The child had a history of asthma and was allergic to dogs. On the night of the fatal incident, the mother and child were at the home of a maternal uncle who had a dog in his home. The child displayed worsening symptoms of his asthma, and the mother administered nebulizer and inhaler treatments to treat the symptoms. On 1/2/2022, the child told the mother he was struggling to breathe and was turning blue. The mother attempted to administer an emergency inhaler treatment, and the child stopped breathing. The child was transported to the hospital by ambulance and was pronounced dead.

ECDSS received the SCR report and coordinated their investigation with law enforcement. The interviews of the mother and maternal uncle confirmed the child displayed signs of suffering asthma attacks throughout the day prior to the fatal incident. The mother administered emergency treatments when symptoms worsened and did not remove the child from the allergens present in the home. The mother and maternal uncle denied substance use the night of the fatal incident and appeared sober and coherent during their interactions with law enforcement and first responders in the home.

ECDSS interviewed the pulmonologist treating the child's asthma. ECDSS was informed the mother admitted to not administering preventative medications as prescribed to the child despite being given written instructions on how to administer them.

ECDSS interviewed the medical examiner. The medical examiner stated the child died of an asthma attack and severe damage was found in his lungs from his asthma not being treated as prescribed. The manner of death was identified as homicide due to the lack of appropriate care.

The allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Medical Care against the mother regarding the child were substantiated. The allegation of Parents Drug/Alcohol Misuse was under investigation at the time this report was written. Services in relation to the death of the child were offered to the mother and declined.

PIP Requirement
ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the LDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, LDSS 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:**
  - **Safety assessment due at the time of determination?** 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 record contained documentation of supervisory consultation and a determination of the allegations was made in accordance to the evidence gathered.

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: 01/02/2022 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 12:15 AM

County where fatality incident occurred: Niagara
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 was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

☐ Distracted
☐ Asleep
☐ Absent
☐ 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	6 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)

LDSS Response

ECDSS received the SCR report and coordinated their response with LE. LE informed ECDSS they responded to the home and the SC was unresponsive upon arrival. The SM and SC were visiting the maternal uncle's (MU) home at the time of the fatal incident. The SC was diagnosed with asthma and was having breathing problems throughout the day and then collapsed in the SM's arms. The MU called 911 and the child was transported by ambulance to the hospital where he was pronounced dead.

ECDSS interviewed with the MU in his home with LE. The MU stated the SC had difficulty breathing throughout the day on 1/1/2022 and the SM administered albuterol treatments by nebulizer between 3-5 times during that day. The MU denied drug and alcohol use that day.

The SM was interviewed in her home by ECDSS and LE. The SM stated the SC had breathing issues throughout the day prior to the fatal incident and she administered nebulizer and inhaler treatments throughout their time at the MU's home. The SM confirmed the SC had allergies to dogs, and there was a dog present in the MU's home. The SM stated she believed the SC was having a panic attack and not an asthma attack at the time of his death. The SM stated the SC approached her, stated he couldn't breathe, and that he was turning blue. The SM stated she attempted to administer an emergency inhaler treatment and the SC took his last breath in her arms. The SM denied being under the influence of any illicit substance at the time of the fatal incident when asked by LE and ECDSS.

ECDSS interviewed the prevention provider for the SM and SC. The provider stated she last saw the SC on 12/30/2021 and had advised the SM to contact the SC's doctor as the SM stated she was administering nebulizer treatments every 4 hours and was giving him two treatments worth of medication when giving the treatments.

ECDSS interviewed the SC's pulmonologist. ECDSS was informed the SC had very poorly managed asthma and the SM admitted she was not giving the SC preventative medications as prescribed. The pulmonologist stated he advised the SM to keep the SC away from cats, dogs, and farm animals, as they would exacerbate his asthma symptoms.

ECDSS interviewed the ME. The ME stated the SC died of an asthma attack and the autopsy showed the SC's lungs were severely damaged from his asthma not being controlled with preventative medications. The ME believed the SC's death would have been prevented had he been given his medications as prescribed. The official manner of death was ruled a homicide due to the lack of appropriate care.

ECDSS interviewed LE investigating the incident. LE informed ECDSS a white powder was removed from the MU's home and tested. It was not an illicit substance and there were no signs of drug use in the home the night of the fatal incident. The criminal investigation was ongoing at the time this report was written.

ECDSS made multiple unsuccessful attempts to contact the BF to the SC. The SM had an elder child who lived out of state with their aunt. The SS was assessed as safe in the care of their aunt.

The allegations of DOA/Fatality, IG, and LMC against the SM regarding the SC were substantiated. The investigation of the second SCR report with an allegation of PD/AM was not determined at the time this report was written. The SM was offered services in relation to the death of the SC which were declined.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes
Comments: The fatality was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059930 - Deceased Child, Male, 6 Year(s)	059931 - Mother, Female, 38 Year(s)	DOA / Fatality	Substantiated
059930 - Deceased Child, Male, 6 Year(s)	059931 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
059930 - Deceased Child, Male, 6 Year(s)	059931 - Mother, Female, 38 Year(s)	Lack of Medical Care	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐

All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Services were offered to the family in relation to the SC's death. The SM declined services citing existing mental health treatment and community supports.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Services were offered in relation to the death of the SC and declined by the SM.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
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)	Allegation Outcome	Compliance Issue(s)
11/09/2021	Deceased Child, Male, 6 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 6 Years	Mother, Female, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
The SCR report alleged the SM had used marijuana and cocaine to the point of impairment while caring for the SC. When under the influence, the SM screamed and yelled at the SC. As a result, the SC was acting out in school. The mother had grabbed and dragged the SC for unknown reasons, and it was unknown if he had been injured.

Report Determination: Indicated | **Date of Determination:** 12/16/2021

Basis for Determination:
ECDSS received the SCR report and initiated their investigation of the allegations. During the investigation, the SM moved three times and the SC was missing school due to the unstable housing situation. Allegations of drug misuse were unsubstantiated due to a lack of credible evidence. Prevention services had been scheduled to close and the services were put back in place to assist the SM with maintaining stable housing and to monitor the SC's asthma and behavioral needs.

OCFS Review Results:
On 11/10/2021, ECDSS was informed of a concern the SC was hospitalized due to an asthma attack. ECDSS did not follow up with the SM or relevant collaterals to ensure the SM was following recommended treatment for the SC's asthma.

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

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)

Summary:
On 11/10/2021, ECDSS was informed the SC had been previously hospitalized for an asthma attack. ECDSS did not follow up with the family or relevant collateral sources to ensure the SM was following the prescribed methods to treat the SC's asthma.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(d)

Action:
ECDSS will address new concerns as they arise with all applicable caregivers and obtain information from relevant collateral sources, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/26/2021	Deceased Child, Male, 5 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 5 Years	Mother, Female, 37 Years	Internal Injuries	Unsubstantiated	

Report Summary:
An SCR report alleged the SM hit the SC with her hand on his face, causing him to bleed, as a form of discipline. There was no visible injury at the time the report was made.

Report Determination: Unfounded **Date of Determination:** 06/22/2021

Basis for Determination:
ECDSS received the SCR report and initiated their investigation. The SM admitted to striking the child in the mouth due to not being able to control his behaviors. The investigation identified concerns for the SM's mental health and the SC's behaviors in school and home. ECDSS obtained collateral information and were informed by the school and a family friend about concerns for the SM's treatment of the SC's asthma. Due to the concerns identified, the family was referred to prevention services to assist the family with addressing the SM's mental health, SC's behaviors, and to ensure the SM was providing adequate treatment for the SC's asthma.

OCFS Review Results:
ECDSS made a determination of the allegations in congruence with the evidence gathered from familial and collateral sources. ECDSS was informed for concerns for the SM's management of the SC's asthma condition. Despite the concerns disclosed, ECDSS did not obtain any collateral information regarding the child's condition and did not know if the SM was following the prescribed treatment plan.

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

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)

Summary:
ECDSS was informed of concerns for the SC in the care of the SM in relation to the SM’s ability to treat and manage the SC’s asthma condition. ECDSS did not document evidence to appropriately determine if this was true or not.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(d)
Action:
ECDSS will address new concerns as they arise with all applicable caregivers and obtain information from relevant collateral sources, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/28/2020	Deceased Child, Male, 4 Years	Mother, Female, 37 Years	Inadequate Food / Clothing / Shelter	Substantiated	No
	Deceased Child, Male, 4 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 4 Years	Mother's Partner, Male, 32 Years	Inadequate Food / Clothing / Shelter	Substantiated	
	Deceased Child, Male, 4 Years	Mother's Partner, Male, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 4 Years	Mother's Partner, Male, 32 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report alleged the SM's paramour was intoxicated and assaulted the SM in the presence of the 4-year-old SC. The SM's paramour pushed and threatened to kill the SM. The SC was uninjured during the altercation. The report alleged the condition of the home was unsafe for the SC and the SM and SM's paramour failed to address the condition of the home.

Report Determination: Indicated | **Date of Determination:** 09/17/2020

Basis for Determination:
ECDSS received the SCR report and initiated their investigation. The DV in the home was confirmed, the SM's paramour was arrested and an OOP was put in place barring contact. ECDSS confirmed the condition of the home to be unsafe for the SC and provided the SM an opportunity to address the areas of concern. The areas of concern were addressed and ECDSS deemed the home safe for the SC. The family was open with services and referred back to continue working with the prevention services in place.

OCFS Review Results:
ECDSS conducted an investigation that met regulatory requirements. The SC was assessed as safe in the care of the SM and prevention services stayed in effect at the time the investigation was closed.

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

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

There were four investigations which occurred more than three years prior to the fatality. One investigation was substantiated and the SC was placed in foster care through an Article 10 placement. There were concerns present at the time for the mother's mental health, the unstable and poor condition of the home, and a history of the mother's illicit drug misuse. The SC was in foster care from March 2018-March 2020

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Required Action(s)

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

Issue:	Coordination of Services
Summary:	A goal was put in the FASP to monitor the child's medical treatment to avoid a medical emergency related to his asthma. There is no documentation in the case record the child's medical treatment was being monitored.
Legal Reference:	18 NYCRR 432.2(b)(4)(i) and 432.2 (b)(4)(viii)
Action:	ECDSS must ensure that the roles, responsibilities and tasks and activities of all service providers are clearly defined and that the established plan of service is being implemented.

Preventive Services History

During the SC's time in foster care, the SM and SC received wrap around services to assist the mother with securing stable housing, monitoring her mental health and substance abuse treatment, and work on reunification. The SC was returned to the care of the SM on 3/9/2020.

Foster Care Placement History

The SC was placed in foster care from 3/19/2018-3/9/2020 due to concerns for the SM's mental health and unstable housing. The SC was returned to the care of the SM with an order of supervision which expired in 12/2020. The long-term case was closed when the order of supervision expired.

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

Regarding the citations related to the CPS investigations conducted during the 3 year period preceding the fatality, we at ECDSS must unfortunately concur with the findings of the reviewer. Specifically, we acknowledge that during the investigations of the SCR reports dated 4/26/21 and 11/9/21, ECDSS did not adequately follow up with the family or relevant collateral contacts to ensure that the subject mother was adequately following recommended treatment methods to address the subject child's asthma. Furthermore, regarding the citation related to the preventive services case, we acknowledge that ECDSS failed to ensure that adequate collateral information was collected to implement the stated goal of monitoring the subject child's medical treatment. As a corrective action plan relative to the aforementioned citations, the following steps will be taken: At an upcoming CPS Team Leader (TL) meeting, all TLs will be directed to remind their caseworkers that all appropriate collateral contacts must be completed prior to report determination. Worker compliance with this will be monitored by the TLs. At an upcoming Children's Services Unit Supervisor (US) meeting, all USs will be directed to ensure that sufficient collateral information is collected to support the adequate monitoring and implementation of all identified preventive services goals. The specific concerns of the CPS investigations cited above will be addressed directly with the respective TLs and caseworkers responsible for those investigations. The specific preventive services concerns cited above will be addressed directly with the Unit Supervisor, caseworker and contracted agency involved with the family at the time of the fatal incident. These concerns of collecting adequate collateral information will continue to be addressed through the ongoing implementation of a consolidated Program Improvement Plan currently being executed by ECDSS with the assistance and support of 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