Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-19-048

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

Issue Date: May 06, 2020

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: 1 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 12/26/2019
Initial Date OCFS Notified: 12/27/2019

Presenting Information

On 12/26/19, Erie County Department of Social Services informed OCFS of the 1-year-old female child's death by completing the 7065 Agency Reporting Form. The child became unresponsive on 12/22/19, was admitted to the hospital and placed on life support until she was declared deceased on 12/26/19. The child was suspected to have died as a result of septic shock and there was no suspicion the child died as a result of the parents' actions or inactions.

Executive Summary

This fatality report concerns the death of the 1-year-old female subject child who died on 12/26/19. The child died during an open CPS investigation regarding concerns the mother incorrectly administered the child medication in the days leading up to the child's death. The child resided with his parents and eight siblings. The siblings were assessed to be safe in the care of the mother and the child's father throughout the investigation.

Erie County Department of Social Services (ECDSS) began gathering information about the incident that led to the fatality after the Department was made aware of the concerns for the child's care on 12/22/19. Due to the family's beliefs, no autopsy was completed; however, a hospital physician said the cause of death was septic shock with acute organ failure due to streptococcus pneumonia.

The parents reported the child was ill in the days leading up to her hospitalization, noting she was lethargic and had a fever. The mother brought the child to the hospital on 12/21/19, as she was concerned for the child's health; however, the child was discharged, and the mother was ordered to administer the child a fever reducer. On 12/22/19, the child became unresponsive and was not breathing. The mother called 911. EMS responded to the home and transported the child to the hospital. The child was placed on life support, which was withdrawn on 12/26/19 and the child was pronounced deceased.

ECDSS gathered information regarding the child's medical condition and subsequent death from hospital and medical staff, and the child's father. The record did not reflect the fathers of the siblings were contacted.

Several home visits were made throughout the investigation, and grief counseling was offered to the family. The mother declined the referral on behalf of the family and no longer wanted to participate with ECDSS. The investigation revealed neither the actions nor inactions of the mother were the result of the child's death. The case was closed without further intervention from ECDSS.

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:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
As the death was not reported to the SCR, there were no requirements to complete Safety Assessments. Additionally, no allegations needed to be determined.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

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

Explain:
The record did not reflect the fathers of the siblings were contacted.

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: 12/26/2019 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 12/22/2019
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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: Not impaired.

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	No Role	Female	1 Year(s)
Deceased Child's Household	Father	No Role	Male	58 Year(s)
Deceased Child's Household	Mother	No Role	Female	41 Year(s)
Deceased Child's Household	Sibling	No Role	Female	17 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)

LDSS Response

On 12/22/19, ECDSS received an SCR report regarding the fatal incident and immediately began their investigation. Within the first 24-hours of the investigation, the parents were interviewed, and medical staff was contacted. The siblings were assessed to be safe.

On 12/22/19, ECDSS interviewed the mother at the hospital with the assistance of the 17-year-old sibling translating. The mother said she noticed on 12/18/19 the child was ill and was not acting herself. She described the child to be lacking energy and had a fever. On 12/21/19 at 2:00 AM, she brought the child to the hospital and they were sent home with instructions to give the child fever reducers. The 17-year-old sibling corroborated the mother's statement.

On 12/22/19, hospital nurses reported the child was extremely ill, on a ventilator and in an unstable condition. It was believed the mother administered too much medication to the child.

The father was interviewed at home on 12/22/19. The siblings were observed and assessed to be free from any injuries. The father said the child was not running around or eating normally in the days prior to her hospitalization. On 12/21/19, after the mother brought the child to the hospital, the father went to the store with a friend to get the prescribed over-the-counter fever reducer for the child and was assisted by the store clerk in choosing the correct medication for the child. The child remained ill following her hospital discharge and on 12/22/19, 911 was called. The father did not think the mother provided the child with too much medication.

On 12/26/19, ECDSS was made aware of the death by the hospital. The hospital staff said the child had been in liver failure. The hospital physician said the cause of death was a result of an infection, not because the mother administered too much medication. The amount of fever reducer found in the child's system was appropriate.

On 12/31/19, ECDSS went to the home and gathered more information from the family. The mother said she showed the physician what medication she was giving the child and was told it was appropriate. The child's condition worsened after she was discharged, and on the next day, the mother called 911, as the child was vomiting blood, was dizzy and her eyes rolled back. The mother declined for ECDSS to interview the siblings regarding the fatal incident and death. They were assessed to be safe in the care of their family and were observed to be free from marks or injuries.

The family was offered bereavement services in response to the fatality; however, the mother declined the services stating they have a strong support group with friends, family and the community. The investigation was unfounded and closed.

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 reviewed by an OCFS approved Child Fatality Review Team? Yes

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☐	☒	☐
At 7 days?	☒	☐	☐	☐

At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐
Explain: There was no requirement to assess the safety of the surviving siblings within 24 hours of learning of the death as it was not suspected to be a result of abuse or maltreatment.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

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:
The mother was offered services in response to the fatality; however, she declined the services on behalf of the family. The record did not reflect funeral assistance was offered to the family.

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? No
Explain:
The mother declined to accept services from ECDSS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother declined services in response to the death.

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?	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?	Yes

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)
12/22/2019	Deceased Child, Female, 1 Years	Mother, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 1 Years	Mother, Female, 41 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
An SCR report alleged the mother gave the 1-year-old female subject child an antihistamine every two hours instead of a fever reducer. The child was not supposed to have the antihistamine due to her age. The child was discovered unconscious and 911 was called. By the time EMS arrived at the home, the child's eyes were open. It was suspected the child was over-medicated with the wrong medication. The mother did not read or speak English. The mother placed the child at risk of harm.

Report Determination: Unfounded | **Date of Determination:** 04/02/2020

Basis for Determination:
The investigation revealed the child appeared to have died from complications of a viral illness, not maltreatment. The physician was contacted and reported the child had appropriate levels of medication in her system and medication did not play a role in her death. The investigation did not reveal any credible evidence to support the allegations; therefore, the allegations were unsubstantiated and the investigation was closed.

OCFS Review Results:
The investigation was initiated timely and the source of the report was contacted. The 7-day Safety Assessment was completed inaccurately, yet timely; however, a Safety Modification was added on 1/9/2020 to accurately reflect case circumstances. The subjects of the report were interviewed and the children were interviewed when appropriate. Although written notice of the SCR report was provided to the parents of the subject child, the record did not reflect the fathers of all of the children were provided with written notice. The record did not reflect ECDSS made attempts to contact the fathers of the siblings. The Risk Assessment Profile was completed with accuracy.

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

Issue:
Failure to provide notice of report

Summary:
Although the parents of the subject child were provided with written notice of the SCR report, the record did not reflect the fathers of the siblings were provided with written notice.

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

Action:
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:
Contact/Information From Reporting/Collateral Source
Summary:
There were missed opportunities to gather collateral information from absent parents. The record did not reflect the fathers of the siblings were contacted and/or interviewed with regard to the SCR report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ECDSS will contact or make diligent efforts to contact relevant collaterals who may have information relevant to the investigation and the safety of the children, including absent parents.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/08/2017	Sibling, Male, 6 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 8 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 11 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 12 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 15 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Other Adult - Father of the four youngest SS, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Years	Other Adult - Father of the four youngest SS, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 10 Years	Other Adult - Father of the four youngest SS, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 11 Years	Other Adult - Father of the four youngest SS, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 12 Years	Other Adult - Father of the four youngest SS, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 15 Years	Other Adult - Father of the four youngest SS, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 8 Years	Mother, Female, 39 Years	Excessive Corporal Punishment	Unsubstantiated	
	Sibling, Female, 8 Years	Other Adult - Father of the four youngest SS, Male, 41 Years	Excessive Corporal Punishment	Unsubstantiated	

Report Summary:
An SCR report alleged the mother and the father of the four youngest siblings would physically fight in the presence of

all the children. While arguing with the father of the siblings, the mother killed a kitten. The mother and father of the siblings hit and kicked the 12-year-old sibling as a form of punishment. On 12/7/17, the adults hit and kicked the sibling for touching money that she was not supposed to touch. It was unknown if the adults hit the other siblings. A subsequent report was received on 1/24/18 which alleged the 6-year-old sibling was inadequately dressed for the weather and was cold.

Report Determination: Unfounded | **Date of Determination:** 04/10/2018

Basis for Determination:
The allegations were unsubstantiated. The investigation revealed the 12-year-old sibling's insufficient oxygen at birth resulted in the sibling making false statements. The case record noted the father of the four youngest siblings and the mother divorced and lived separately, and the children had not seen their father. There was no credible evidence to support the 6-year-old sibling was inadequately dressed for the weather.

OCFS Review Results:
The investigation was initiated timely and the sources of the reports were contacted. ECDSS made appropriate collateral contacts and interviewed the family. ECDSS provided safe sleep information to the mother as she was pregnant. The 7-day Safety Assessment was not completed timely and written notice of the SCR report was not provided timely. Attempts were made to contact the fathers of the children, and the interviewers with the children were adequate. ECDSS documented casework activity in a timely manner.

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

Issue:
Failure to provide notice of report
Summary:
Although the adults were provided written notice of the subsequent SCR report, the letters were provided on 1/29/18. Only the father of the older siblings was provided with written notice regarding the subsequent report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ECDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
Although completed accurately, the 7-day Safety Assessment was not completed timely. The Safety Assessment was completed on 12/18/17.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
ECDSS will complete all Safety Assessments timely and adequately in the accordance with regulations.

[redacted]

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

10/15/10-12/17/10 The mother was unsubstantiated for Inadequate Guardianship of the siblings.

10/25/13-7/8/14- The mother and father of the younger siblings were substantiated for XOTH and Inadequate Guardianship regarding the siblings.

Known CPS History Outside of NYS

There was no known CPS history outside of the state.

Preventive Services History

On 6/19/14, a Preventive Case was opened after a referral was made by a CPS worker. Erie County Department of Social Services filed a Neglect Petition regarding the family. The mother and the father of the younger half of the siblings were court-ordered to services after there was credible evidence to support the father of the younger siblings sexually abused other children and the mother failed to protect the siblings. During the open Preventive Case, the mother and father of the younger siblings divorced, and he moved out of the home. The case was closed in 7/15/16, as the mother achieved all services goals. At the time of case closure, the whereabouts of father of the younger siblings were unknown and there were warrants out for his criminal arrest for unknown charges.

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 response in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. Unfortunately, we must concur with the compliance issues cited by the reviewer. Specifically, with respect to the State Central Registry (SCR) report dated December 22, 2019, we acknowledge that Notices of Existence were not sent to the fathers of the subject child's siblings, nor were these fathers contacted or interviewed as collateral resources. We further acknowledge, with respect to the SCR report dated December 8, 2017, that Notices of Existence on the initial report were mailed several weeks late, and only the father of the older sibling was mailed a Notice of Existence on the subsequent report. Finally, we concur that the 7-day safety assessment completed for the report dated December 8, 2017 was completed three days late. Please be advised that a comprehensive Performance Improvement Plan developed in conjunction with the OCFS Buffalo Regional Office and currently being implemented by ECDSS covers the above identified compliance issues.

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