Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-19-001

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

Issue Date: Jul 03, 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: 6 year(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 01/01/2019
Initial Date OCFS Notified: 01/02/2019

Presenting Information

An SCR report made on 1/2/19 alleged a 6yo foster child (SC) with a seizure disorder was prescribed daily medications and a rescue medication. The morning of 1/1/19, his FF picked him up from a caretaker, brought him home, and gave him his daily medications. While attempting to dress, the SC fell to the ground and hit his head. The SC gasped for breath on the floor with his tongue out of his mouth. He had a seizure lasting approximately 15 minutes. The FF called a nurse who worked with the SC, and the nurse said to call 911 which the FF then did. The FF did not have the rescue medication to be given during seizures. When EMS arrived, the SC was in cardiac arrest with no pulse. Additionally, the SC allegedly presented at the ER with an acute subdural hematoma and burns to his chest, groin and stomach. The FF's explanation was inconsistent. The SC passed away later that day. A report with a similar narrative had been made on 1/1/19 regarding the fatal incident, prior to the death.

Executive Summary

This report concerns the death of a 6yo foster child who died after an incident occurred in the care of his FF. An SCR report made on 1/1/19 alleged the FF did not possess or administer medication to the SC as required, and the SC had unexplained injuries. When the SC later died, a subsequent report alleged the FF's inactions contributed to the death.

Hospital records showed the SC presented with cardiac arrest and suspected prolonged activity of an acute episode of his medical condition. Exams revealed brain swelling and bleeding. Hospital staff described the SC had "burn-like injuries" from his chest to his groin. The SC's condition declined, and he was later pronounced dead.

Erie County Department of Social Services (ECDSS) investigated the fatality. Their FC, CPS and FC agency staff responded to the hospital to gather information and support the family.

The SC's apparent symptomatic episode occurred around 8:20 AM on 1/1/19 at the FF's girlfriend's home. The FF responded the way he was trained and called for help. He looked for the rescue medication prior to calling the FC agency's nursing staff and 911. He said he regularly had the medicine on hand but could not find it at the time of the incident; he was also unable to produce it afterward. As there was no evidence he regularly carried the medication with the SC as prescribed, the FF was indicated for LMC and IG.

The family reported the SC recently had a reaction to a hygiene product causing skin irritation and peeling. The SC was known by the FF, school, FC agency and ECDSS to frequently bang his head against things in frustration; he wore a helmet during school hours because a setting with the recommended 1:1 teacher-to-student ratio was unavailable. The FF and school staff noted in December that the SC was more lethargic than normal and sometimes shook or quivered; the FC agency's nurse was aware and consulted the SC's doctor, who reviewed bloodwork and medications and had no concerns. The neurologist was informed and it was noted this did not warrant an appointment sooner than previously scheduled.

The ME was unable to conclusively state whether the SC suffered the type of episode suspected or if another medical event occurred; she explained there was no way to know if the rescue medication would have prevented the death even if the type of episode was known. The ME was unable to state with medical certainty the cause of the skin condition, whether irritated abrasions or a type of burn; further tests were ordered. Though the SC had head injuries, the ME could not confirm their relation to the fatality. ECDSS considered the information provided as well as the behavioral history when determining allegations; the autopsy report remained pending at the time of this writing. The LE investigation was

open pending the final autopsy report and no arrests had been made. As the cause of the death and injuries were inconclusive, ECDSS unsubstantiated all other allegations.

The SC had been in ECDSS custody since three months of age, after sustaining injuries that caused his lifelong ailments. He was survived by four siblings who he visited regularly; they were informed of the fatality. The SC was in the FF's care since 11/9/18.

ECDSS conducted safety assessments of children who had regular contact with the FF: his sister's three children and his girlfriend's two children. They were medically examined and no concerns were revealed. There were no apparent safety concerns for the SS.

Fatality-related services were offered, and the investigation closed 3/4/19.

Over the years the SC was in FC, there were instances of insufficient planning and communication among ECDSS and the FC agencies that impacted safety, permanency and wellbeing. In 2018, the new FC agency identified a need to assist the FF with creating plans for childcare due to his work schedule and approve resources. This was not addressed while the SC was in FF's care. The approved resource was not being used. Neither she nor the resource who was being used received critical information of the SC's diagnoses and medical care plans. In 2016, a different FC agency did not identify and mitigate risk factors, resulting in a serious incident requiring the SC to be moved and separated from his siblings. The SC's risky behaviors were not disclosed to the current FF, leaving him unprepared for a possible similar situation.

Though some concerns were noted in review of the FC case, it was evident ECDSS and their contracted agencies made considerable efforts to maintain appropriate placement for the SC. Despite these diligent efforts to adhere to the standards for continuity and appropriate placement, the standards were not always able to be upheld due to unavailability of resources.

PIP Requirement

For citations regarding the Foster Care Services case, 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:**
    - **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

Explain:
Safety assessments were timely and appropriate. The determination of allegations was appropriate given the supportive evidence gathered.

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 decision to close the case was appropriate. There was documentation of supervisory consultation, and casework activity was commensurate with case circumstances.

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: 01/01/2019 **Time of Death:** 06:40 PM

Time of fatal incident, if different than time of death: 08:19 AM

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 08:42 AM
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: Getting dressed

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	Alleged Victim	Male	6 Year(s)
Deceased Child's Household	Foster Parent	Alleged Perpetrator	Male	27 Year(s)
Deceased Child's Household	Other Adult - Foster Father's Mother	No Role	Female	53 Year(s)
Other Household 1	Other Adult - Foster Father's Partner	No Role	Female	32 Year(s)
Other Household 1	Other Child - Child of Foster Father's Partner	No Role	Male	6 Year(s)
Other Household 1	Other Child - Child of Foster Father's Partner	No Role	Male	10 Year(s)
Other Household 2	Other Adult - Other Children's Biological Father	No Role	Male	36 Year(s)

LDSS Response

ECDSS promptly responded to the SCR reports regarding the fatal incident and additional allegations made the following day. ECDSS thoroughly investigated the death by coordinating with LE and interviewing medical staff, providers, the FF, and family members.

In the first 24 hours, ECDSS conducted safety assessments of the surviving children. As the FF and SC frequented FF's girlfriend's home, ECDSS interviewed her and encouraged medical assessments of her children, ages 6 and 10. ECDSS also saw to having the FF's nephew and nieces assessed (ages 7, 4, and 15 months) as the SC had been in their home just prior to the fatal incident. All children were deemed medically well and those who were interviewed revealed no concerns. The foster home was temporarily closed during the investigation.

The FF described the events leading up to the fatality: Around 7 AM on 1/1/19, he picked the SC up from his sister's home, who had watched the SC while the FF worked overnight. The FF woke the SC and drove him to his girlfriend's home; she and her children were not present at the time. He sent the SC to use the bathroom and when he finished, the FF administered his daily medications and helped him dress. While the SC was attempting to pull up his pants, he fell and hit his head on the carpeted floor and possibly an adjacent wall. He began exhibiting symptoms known to the FF as those from his medical condition. The FF responded as trained then went looking for the rescue medication, unable to locate it. He called a nurse at the FC agency who advised him to call 911. The FF did so, and prepared the SC for a dose of rescue medication, which he anticipated EMS would administer. He said he was instructed over the phone to monitor the SC's breathing and to not perform CPR. EMS arrived and made life-saving efforts, then transported the SC to the hospital. Upon admission, he was seen by multiple specialists and underwent an array of examinations; he had no brain activity and later died.

Despite the pending status of the autopsy report throughout the investigation, important information was gathered from the ME to support the findings of the CPS case. Essential data was shared between ECDSS and LE, who planned to keep their case open until the final results were available.

The FF was tested for substances and the results were negative; there was no evidence he was impaired at the time of the incident.

From ECDSS's interviews, they learned nothing eventful occurred at the FF's sister's home while the SC was in her care; he had slept throughout the night. She said the FF did not inform her about a rescue medication and she did not observe a bag for the SC that may have contained the medicine. The FF's mother did not have information to explain the fatality; however, all adults interviewed corroborated the SC had irritated skin that he picked at, and occasionally exhibited behaviors of self-harm such as head-banging. The FC agency had been aware the FF was working on appropriate behavioral strategies to manage this.

The FF acknowledged he was to always have the rescue medication with the SC. Previous notes in the FC case described the specific actions to be taken during such an episode as communicated to the FF. A progress note documenting a home visit on 12/17/18 by ECDSS and the FC agency recorded that the case planner checked the SC's medications, noting there had been no changes and they were locked up. The FC agency later expressed concerns that the FF was not completely forthcoming to them about medical issues prior and unrelated to the fatality, though it had been documented they maintained frequent communication and the FF appeared willing and able to address all SC's needs.

ECDSS closed the investigation after sufficient facts were gathered in which to make an informed determination. The final note in the FC case dated 1/1/19 documented the joint response at the hospital. The FC case closed 4/29/19.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or 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 reviewed by an OCFS approved Child Fatality Review Team?No
Comments: This fatality has not yet been reviewed by the Erie County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
049610 - Deceased Child, Male, 6 Yrs	049611 - Foster Parent, Male, 27 Year(s)	Inadequate Guardianship	Substantiated
049610 - Deceased Child, Male, 6 Yrs	049611 - Foster Parent, Male, 27 Year(s)	Internal Injuries	Unsubstantiated
049610 - Deceased Child, Male, 6 Yrs	049611 - Foster Parent, Male, 27 Year(s)	Burns / Scalding	Unsubstantiated
049610 - Deceased Child, Male, 6 Yrs	049611 - Foster Parent, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
049610 - Deceased Child, Male, 6 Yrs	049611 - Foster Parent, Male, 27 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?	☒	☐	☐	☐

Additional information:
The father of the foster father's girlfriend's children, who was appropriately added to the case, was interviewed over the phone.

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:
A provider recommended MH services for the FF after an evaluation, but it was unknown if he engaged due to an insurance barrier. The FF, his mother, and his girlfriend's children were given information on grief counseling services. The FF completed a substance abuse evaluation as requested by ECDSS; no further substance abuse services were needed.

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:
Information on counseling services was sent to the foster father's girlfriend for her children. There was no evidence in this child's record that services were offered or provided to the child's siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The foster father was provided a mental health assessment, though further services did not appear to be used while the investigation was open. The FF and his mother were given information on grief services. ECDSS made funeral arrangements for the SC.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? 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? Yes
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)
08/26/2016	Deceased Child, Male, 4 Years	Other Adult - FM's Adult Daughter, Female, 23 Years	Inadequate Guardianship	Substantiated	No

Deceased Child, Male, 4 Years	Other Adult - FM's Adult Daughter, Female, 23 Years	Lack of Supervision	Substantiated
Deceased Child, Male, 4 Years	Other Adult - FM's Daughter's Partner, Female, 21 Years	Inadequate Guardianship	Substantiated
Deceased Child, Male, 4 Years	Other Adult - FM's Daughter's Partner, Female, 21 Years	Lack of Supervision	Substantiated
Deceased Child, Male, 4 Years	Foster Parent, Female, 45 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Male, 4 Years	Foster Parent, Female, 45 Years	Lack of Supervision	Unsubstantiated

Report Summary:
An SCR report alleged the SC's foster mother was aware there was a previous incident of the SC wandering from the home, and that he required a higher level of supervision. The SC suffered from developmental and medical disorders which placed him at higher risk if he were to wander from the residence. On 8/26/16, a neighbor found the SC wandering outside the residence unsupervised at 12:30 AM. The SC was unharmed and was returned to the home. His 6- and 12-year-old siblings, also foster children in that home, had unknown roles. The same allegations were later added for two additional caregivers for their similar knowledge and alleged failure to act.

Report Determination: Indicated | **Date of Determination:** 09/12/2016

Basis for Determination:
ECDSS noted the foster mother, her adult daughter, and a parent substitute at that home knew the SC's tendency to leave the home due to a prior incident. After that first incident, the foster mother had taken proper safety measures to secure her home; however, the children spent most of their time at her adult daughter's home. This adult was not a certified foster parent, and there were no comparable safety measures in her home. The SC escaped from that home in the manner alleged. The children were then placed in alternate foster care settings. Though all three adults were initially indicated, allegations against the foster mother were overturned after an administrative review.

OCFS Review Results:
Though the investigation was complete and the protective actions were appropriate, OCFS's review of the concurrent FC services case revealed partial responsibility on behalf of the agencies involved in the FC case for failing to identify, address, and mitigate risk. At minimum, the FC agency and ECDSS in their oversight role knew the children spent a significant amount of time at the FM's daughter's home, including overnight visits. The agency communicated frequently with the FM's daughter and visited her home often, though neither agency enforced the requirement for the alternate caregiver to meet the same safety standards as the FM's home.

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

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

The SC was survived by four siblings. Their history was not included, as the parents' rights were terminated to all children prior to the fatality. All siblings were adopted in 2018.

The day after the SC's birth, a report was made against his mother alleging she appeared unable to physically and emotionally care for him. ECDSS closed the case two weeks later, finding the mother had adequate supplies and appeared able to care for him. Two months after the case closed, another report was made when the SC was found with extensive unexplained head injuries. Though the injuries remained unexplained, it became medically concluded they resulted in developmental delays and lifelong medical conditions. A neglect petition was filed against his mother and alleged father, and the SC and his siblings were removed on 10/22/12. Since that date, the SC never left foster care.

In September 2013, six reports were made against the SC's foster mother (FM) and consolidated into one investigation. Allegations included C/T/S, IF/C/S, IG, LS, PD/AM, and SA. A parent substitute was also alleged of IG and LS. All

allegations were Unsub. In August 2015, a report was UNF against the same FM. The report alleged the SC was found wandering the street with no supervision, wearing only a diaper. Although this occurred, ECDSS found this was the first incident and the FM was unaware the SC could unlock doors and leave the home. The FM promptly installed extra security alarms and locks.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The most recent FASP prior to the fatality - an important FASP to reflect the significant change in care and custody - was completed eight days past the date it was due, and it was approved twenty-nine days past the date it was due.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Foster Care at the Time of the Fatality

The deceased child(ren) were in foster care at the time of the fatality? Yes
Date deceased child(ren) was placed in care: 10/22/2012
Date of placement with most recent caregiver? 11/09/2018
How did the child(ren) enter placement? Court Order

Review of Foster Care When Child was in Foster Care at the time of the Fatality

	Yes	No	N/A	Unable to Determine
Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?	☒	☐	☐	☐
Did the placement comply with the appropriateness of placement standards?	☒	☐	☐	☐
Was the most recent placement stable?	☒	☐	☐	☐
Did the agency comply with sibling placement standards?	☒	☐	☐	☐
Was the child AWOL at the time of death?	☐	☒	☐	☐

Visitation

	Yes	No	N/A	Unable to Determine
Was the visitation plan appropriate for the child?	☒	☐	☐	☐
Was visitation facilitated in accordance with the regulations?	☒	☐	☐	☐
Was there supervision of visits as required?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource made with required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource in the parent/relative/discharge resource's home made with required frequency?	☒	☐	☐	☐
Were all of the casework contact requirements for contacts with the caretakers made, including requirements for contact at the child's placement location?	☒	☐	☐	☐

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the agency provide the foster parents with required information regarding the child's health, handicaps, and behavioral issues?	☐	☒	☐	☐
Did the provider comply with discipline standards?	☒	☐	☐	☐
Were the foster parents receiving enhanced levels of foster care payments because of child need?	☒	☐	☐	☐
If yes, was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	☒	☐	☐	☐
Was the certification/approval for the placement current?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:** 12/15/2017	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:** 10/01/2018	☒	☐	☐	☐
Was a check completed through the Staff Exclusion List? **Date:** 05/31/2018	☒	☐	☐	☐

Additional information, if necessary:
The agency was required to provide FF with information on SC's needs. SC had an exceptional need level which required

them to see that FF could provide the intensive supervision consistent with SC's therapeutic goals. FF was not given facts from SC's past relevant to his current safety, and appropriate plans for child care were not addressed.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☒Yes ☐No

Issue:	Timeliness of completion of FASP
Summary:	The most recent FASP - essential to reflect the significant change in agencies, care, and custody - was completed eight days past the date it was due, and it was approved 29 days past the due date. However, numerous FASPs completed prior were timely.
Legal Reference:	18 NYCRR428.3(f)
Action:	ECDSS will complete, or see to the completion of FASPs by service providers when applicable, in a timely fashion when ECDSS maintains a case management role.
Issue:	Adequacy of foster home certification, approval training, or monitoring
Summary:	Basic information important to SC's needs was not provided to FF. Also, FF used a relative as a resource in his absence who was not agency-approved. A different relative was, but was uninformed of SC's needs. Necessary child care was not monitored.
Legal Reference:	18 NYCRR Part 443
Action:	Agencies must prepare a foster parent (FP) with appropriate knowledge and skills to provide for a CH's specific needs, and provide them basic information about the CH including that of handicaps/behavioral problems. A FP's employment must be permitted when there are suitable plans for the care and supervision of the child at all times; plans must be documented and receive prior agency approval.

Foster Care Placement History

The SC was removed from his parents on 10/22/12 via court order for abuse/neglect and placed in the custody of relatives. ECDSS worked to provide an array of services; however, reunification was unsuccessful and his mother's rights were later terminated (paternity was never officially established). On 2/5/13, the SC was placed with a FM who intended to adopt, where he remained for three years. The SC was freed for adoption on 12/9/14. In September 2016 following the indicated CPS case, the SC was relocated to a residential treatment center with Children and Family Services of Erie County (CFS) as no available foster parents were identified to care for the SC, including those with whom his siblings were placed. After only two months at CFS, it was determined such center was not an appropriate placement type for the SC following an evaluation; his specified service needs did not warrant institutional placement. CFS and ECDSS made continuous diligent efforts during his stay to find a more appropriate placement, though despite these efforts, he remained there for two years. A CFS staff member began the certification process to become a FF for the SC in September 2017. The certifying agency, Hillside Children's Center, acquired the oversight role on 11/9/18, the date the SC entered the FF's care. Throughout his time in FC, the SC was provided necessary services and medical care.

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

The Erie County Department of Social Services (ECDSS) is pleased there are no citations related to the fatality investigation. Regarding two citations related to foster care service provision, ECDSS concurs with one citation and partially concurs with the other. We agree the most recent FASP was completed eight days past the due date and approved 29 days past the due date. A pre-existing Performance Improvement Plan currently being developed with OCFS Buffalo Regional Office covers the issue of late FASPs. Regarding the adequacy of foster home certification, approval training, or monitoring, the ECDSS Foster/Adoption Division notes the Foster Father was indeed aware of the Subject Child's needs. The Foster Father was a staff member of Conners Children's Center, where the Subject Child resided prior to moving to the Foster Father's home; the Foster Father became a certified foster parent through Hillside Agency specifically for the purpose of fostering the Subject Child. The Foster Father was provided with all required therapeutic training by his foster agency; documentation of this is available upon request. As per Hillside Agency, the agency does not train resources on medical protocol and relies upon foster parents to instruct their resources. In response to this portion of the citation, at the time of scheduled Service Plan Reviews, ECDSS will ensure resources utilized by a foster parent are knowledgeable regarding the needs of a child in care and are informed of protocols necessary to meet those needs.

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