Child Fatality Report

Report Identification Number: BU-19-044

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

Issue Date: Feb 26, 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: 6 year(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 01/01/2019
Initial Date OCFS Notified: 09/16/2019

Presenting Information

On 9/16/19, the SCR received a new report on a previously reported fatality about the death of the 6-year-old subject child. On 1/1/19, the subject child who was a special needs child and had a history of seizures, sustained head injuries and burns to his stomach and torso while in the care of the foster father. The foster father said the subject child had a seizure and fell forward hitting his head. The foster father was unable to find the emergency medication needed for the seizure and called 911. EMS transported the subject child to the hospital and he was pronounced dead eight hours later. There was no medical finding that the subject child had a seizure on 1/1/19. The foster father said the burns found on the subject child were caused by shampoo. The foster father's explanations as to how the subject child sustained the injuries were inconsistent with the injuries sustained by the subject child.

Executive Summary

The SCR reported fatality received by Erie County Department of Social Services (ECDSS) on 9/23/19 concerns the death of a 6-year-old subject child that occurred on 1/2/19. A previous fatality report was issued on 7/3/19 regarding the death. On 9/16/19, the fatality was re-reported to the SCR. The medical examiner's report contained additional information about the death of the child.

The previously reported fatality received from the SCR on 1/1/19 alleged the foster father did not possess or administer medication to the subject child as required, and the subject child had unexplained injuries. When the subject child later died, a subsequent report was received on 1/2/19 alleging the foster father’s inactions contributed to the death.

The hospital records showed the subject child 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 subject child had “burn-like injuries” from his chest to his groin. The subject child’s condition declined, and he was later pronounced dead.

In the previously reported fatality, the medical examiner's preliminary findings were inconclusive pending further testing. There were no arrests and law enforcement’s case remained open pending the final autopsy results.

ECDSS substantiated the allegations of lack of medical care and inadequate guardianship against the foster father. The subject child’s apparent symptomatic episode occurred around 8:20 AM on 1/1/19 at the foster father’s girlfriend’s home. The foster father responded the way he was trained and called for help. He looked for the rescue medication prior to calling the Foster Care 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. There was no evidence he regularly carried the medication with the subject child as prescribed. The allegations of DOA/fatality, internal injuries and burns/scalding were unsubstantiated. The case was indicated and closed. The indication was subsequently overturned after an administrative review and was legally sealed.

ECDSS thoroughly addressed the new report about the previously reported fatality and pulled forward all necessary documentation from the case record. The information remained unchanged, except for what was learned in the final autopsy report. Despite the new information, there was still no admission of anyone inflicting injury to the subject child. The foster father’s account of the fatality was the same.

The medical examiner's final autopsy report revealed a healing partial thickness burn of the torso and medial thighs, as well as scattered minor blunt injuries to all the body regions. There was significant blunt force trauma of the head and neck, including numerous scalp contusions, subdural hemorrhage, cervical nerve root hemorrhages and diffuse axonal injury. Evidence of a remote traumatic brain injury was also present. The number, type and severity of the recent head and neck injuries were inconsistent with accidental or self-inflicted trauma, as reported by the foster father. The manner of death was homicide and the cause of death was blunt force injuries of the head and neck.

At the time of this writing, no arrests had been made and law enforcement's investigation remained open. As a result of the medical examiner's findings, ECDSS filed an Article 10 Severe Abuse Petition in Family Court and the Court case was pending further proceedings at the time of this writing. The foster father had no other children in his care, and his license as a foster parent was revoked.

ECDSS substantiated the allegations of DOA/fatality, burns/scalding, lack of medical care and inadequate guardianship against the foster father for the subject child. The case was indicated and closed.

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:
This was a re-reported fatality investigation. There was new information obtained and based on the new information, ECDSS substatiated the allegations of DOA/fatality, burns/scalding, lack of medical care and inadequate guardianship against the foster father for the subject child and filed an Article 10 Severe Abuse Petition in Family Court.

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:
ECDSS indicated and closed their investigation. The foster father had no other children in his care and refused to speak with ECDSS any further about the events leading up to the subject child's death. The foster father's license was revoked and his FAD case had been closed.

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)

LDSS Response

This fatality report concerns the death of a 6-year-old subject child that occurred on 1/2/19. A previous fatality report was issued on 7/3/19 regarding the death. On 9/16/19, the fatality was re-reported to the SCR. The medical examiner's final report contained additional information about the death of the child.

In the previously reported fatality 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 law enforcement and interviewing medical staff, providers, the foster father and family members.

In the previously reported fatality, the foster father described the events leading up to the fatality as follows: Around 7 AM

on 1/1/19, he picked the subject child up from his sister's home, who had watched the subject child while the foster father worked overnight. The foster father woke the subject child and drove him to his girlfriend's home; she and her children were not present at the time. He sent the subject child to use the bathroom and when he finished, the foster father administered his daily medications and helped him dress. While the subject child 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 foster father as those from his medical condition. The foster father responded as trained then went looking for the rescue medication, and was unable to locate it. He called a nurse at the Foster Care agency who advised him to call 911. The foster father called 911 and prepared the subject child for a dose of rescue medication, which he anticipated EMS would administer. He said he was instructed over the phone to monitor the subject child's breathing and to not perform CPR. EMS arrived and made life-saving efforts, then transported the subject child 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.

From ECDSS's interviews, they learned nothing eventful occurred at the foster father's sister's home while the subject child was in her care.

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

The circumstances leading up to the subject child's death were the same as the previously reported fatality. The foster father's account of the events leading up to the death of the subject child remained the same. The foster father made no admission to ECDSS or law enforcement.

Based on the medical examiner's final autopsy report that listed the manner of death as homicide and cause of death as blunt force trauma to the head and neck, ECDSS filed an Article 10 Severe Abuse Petition against the foster father for the subject child. The Family Court Case was pending further proceeding and law enforcement's case remained open and there were no arrests at the time of this writing.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052942 - Deceased Child, Male, 6 Yrs	052943 - Foster Parent, Male, 27 Year(s)	DOA / Fatality	Substantiated
052942 - Deceased Child, Male, 6 Yrs	052943 - Foster Parent, Male, 27 Year(s)	Burns / Scalding	Substantiated
052942 - Deceased Child, Male, 6 Yrs	052943 - Foster Parent, Male, 27 Year(s)	Inadequate Guardianship	Substantiated

052942 - Deceased Child, Male, 6 Yrs	052943 - 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?	☒	☐	☐	☐

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?

☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
11/22/2019	There was not a fact finding	There was not a disposition
Respondent:	052943 Foster Parent Male 27 Year(s)	
Comments:	Based on the Final Autopsy report results listing the cause of death was blunt force injuries of the head and neck and the manner of death homicide, ECDSS filed an Article 10 severe abuse petition in Family Court against the foster father for the subject child. At the time of this writing the case was still pending in Family Court. There were no other children in the care of the foster father.	

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 foster father was given information on grief counseling services. The foster father completed a substance abuse evaluation at the time of the previously reported fatality 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? N/A
Explain:
The foster father had no other children in his care and his foster care license was revoked and his FAD case closed.

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?	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 adult daughter, Female, 21 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 4 Years	Other Adult - FM adult daughter, Female, 21 Years	Lack of Supervision	Substantiated	
	Deceased Child, Male, 4 Years	Other Child - FM daughter, Female, 23 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 4 Years	Other Child - FM daughter, Female, 23 Years	Lack of Supervision	Substantiated	

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 remained in 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 - the 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:** 12/17/2017	☒	☐	☐	☐
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:	Adequacy of foster home certification, approval training, or monitoring
Summary:	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:	The Buffalo Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS in the previously issued fatality report. ECDSS will continue to work on this issue and revise their current PIP if deemed necessary.
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:	The Buffalo Regional Office informed there is currently an existing PIP in place for this issue, as a result of a prior finding by OCFS in the previously issued fatality report. ECDSS will continue to work on this issue and revise their current PIP if deemed necessary.

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

We at the Erie County Department of Social Services (ECDSS) appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased there are no citations related to the fatality investigation or to the CPS investigation conducted within the three year period preceding the fatality. 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 recent Performance Improvement Plan (PIP) developed with the OCFS Buffalo Regional Office covers the issue of late FASPs, and this PIP post-dates the cited compliance issue. 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