Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-16-016

Prepared by: Albany Regional Office

Issue Date: Mar 22, 2017 **(Report was reissued on: Aug 18, 2017)**

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		
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
CPR-Cardiopulmonary Resuscitation		
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

Case Information

Report Type: Child Deceased
Age: 13 year(s)
Jurisdiction: Saratoga
Gender: Male
Date of Death: 08/15/2016
Initial Date OCFS Notified: 08/15/2016

Presenting Information

On 8/15/16 a subsequent report was received by Saratoga County DSS that alleged; On 8/15/16 at approximately 1:00pm a 13 yr. old victim was discovered in the family residence unresponsive by his mother. Several unknown pills and marijuana were found in the home where the child had access.

Executive Summary

On 8/15/16 Saratoga Co. DSS received a subsequent report that included allegations of DOA/ Fatality, Child Drug/Alcohol Misuse and Inadequate Guardianship against the biological mother. The SCDSS caseworker was in immediate contact with Saratoga Law Enforcement at which time the caseworker provided further information related to the case history and current open case. The caseworker was included in a number of internal case conferences in moving forward with the preliminary investigation. On 8/15/16 the SCDSS caseworker and police conducted the initial interview with the biological mother and the maternal grandfather following the fatality. It was determined that the biological mother contradicted herself several times during the course of the interview pertaining to a number of aspects of the incident. In terms of where she kept her medications, the mother initially reported her medications were stored in a lock box, than stated they were in her purse and later stated they were in a pill case on the coffee table. In addition to the prescription medication, marijuana was discovered in the home. The mother denied any drug use and was unable to provide an explanation why marijuana was found in the residence. The mother's reported time frame related to her location when she fell asleep also changed. Her initial statement was that she fell asleep in the recliner next to her son who was on the couch too she then went to her bedroom with her purse and lock box at approximately 1:30am. The mother reported twelve hours had passed before she woke up and found the deceased child. The mother denied that the child had any history of suicide attempts. During the initial stages of the investigation the mother reported that she picked up several pills from the scene, near the child's deceased body prior to the police arriving. A search warrent was issued by the Saratoga Sherriff's Department for the family residence. Various pills, pill grinder and marijuana were all located in near proximity of the child's deceased body. On 8/16/16 the SCDSS caseworker spoke with the coroner from Saratoga County and was informed that the deceased child's body was transported to Albany Medical Center where an autopsy was scheduled to be performed. The child was pronounced dead on 8/15/16 at 1:00pm. The preliminary findings showed no signs of trauma, however noted a large amount of medications were found near the deceased child's body, therefore the cause of death was pending the results from toxicology. On 8/23/16 the SCDSS caseworker conducted a second face to face interview with the mother and maternal grandfather at the LDSS office. The caseworker provided the mother with information for mental health/grief counseling services. The caseworker later spoke with the biological father and learned that his contact with the deceased child had been inconsistent over the past several months prior to the fatality. During the course of the investigation the SCDSS caseworker confirmed that the mother failed to follow through with recommendations for mental health counseling for the deceased child. On 8/24/16 the mother was hospitalized. On 10/7/16 the mother committed suicide. On 10/26/16 Saratoga County substantiated the allegations of Inadequate Guardianship, DOA and Child Drug/ Alcohol Misuse against the mother and the case was closed. The basis for the determination was as follows: The mother failed to properly secure her prescription medications as a result the deceased child had access and on 8/15/16 the child consumed a lethal combination/dose of medications. The mother failed to provide a reasonable minimum degree of care as a result placed the child at imminent danger.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

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

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
After the fatality on 8/15/16 the mother committed suicide on 10/7/16. There were no other children in the household.

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: 08/15/2016 **Time of Death:** 01:00 PM

County where fatality incident occurred: Saratoga
Was 911 or local emergency number called? Yes
Time of Call: 12:55 PM
Did EMS to respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Yes
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? No - Not needed given developmental age or

circumstances

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	13 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)

LDSS Response

On 8/15/16 Saratoga Co. DSS received a subsequent report that included allegations of DOA/ Fatality, Child Drug/Alcohol Misuse and Inadequate Guardianship against the biological mother. The SCDSS caseworker was in immediate contact with Saratoga Law Enforcement and provided further information related to the case history and current open case. The caseworker was included in a number of internal case conferences in moving forward with the preliminary investigation. On 8/15/16 the SCDSS caseworker and police conducted the initial interview with the biological mother and the maternal grandfather following the fatality. The SCDSS caseworker was notified that a search warrant was being initiated by Saratoga Sherriff's Department. On 8/16/16 the SCDSS caseworker spoke with the coroner from Saratoga County and was informed that the deceased child's body was transported to Albany Medical Center where an autopsy was scheduled to be performed. On 8/23/16 the SCDSS caseworker conducted a face to face interview with the mother and paternal grandfather at the LDSS office. The caseworker provided the mother with information for mental health/grief counseling services. The caseworker later spoke with the biological father and learned that his contact with the deceased child had been inconsistent over the past several months prior to the fatality. During the course of the investigation SCLDSS and law enforcement proceeded in a joint investigation. The SCDSS caseworker spoke with the deceased child's service provider's related to his counseling and compliance and learned that the deceased child attendance had been inconsistent. On 8/24/16 the mother was hospitalized. On 10/7/16 the mother committed suicide. There were no surviving children in the household. On 10/26/16 Saratoga County indicated the allegations of Inadequate Guardianship and Child Drug/ Alcohol Misuse against the mother and the case was closed.

Official Manner and Cause of Death

Official Manner: Pending
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)?No
Comments: The LDSS conducted a joint investigation with Law Enforcement and communicated with all appropriate collaterals during the course of the CPS investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: A CFRT currently doesn't exist in Saratoga County DSS.

Child Fatality Report

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
032330 - Deceased Child, Male, 13 Yrs	032331 - Mother, Female, 39 Year(s)	Childs Drug / Alcohol Use	Substantiated
032330 - Deceased Child, Male, 13 Yrs	032331 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Substantiated
032330 - Deceased Child, Male, 13 Yrs	032331 - Mother, Female, 39 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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: N/A							

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:
There were no other children in the household. The deceased child had an adult sibling who did not reside in the residence.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The biological mother was offered mental health/ grief counseling.

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?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
04/08/2016	Deceased Child, Male, 13 Years	Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded	Yes
	Deceased Child, Male, 13 Years	Mother, Female, 39 Years	Educational Neglect	Unfounded	
	Deceased Child, Male, 13 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The report alleged that the mother abused prescription pain medication to the extent that she becomes in incoherent and unable to adequately care for the thirteen-year- old subject child. The thirteen-year-old child is currently out of school for medical reasons and as a result is provided tutoring, however the mother doesn't ensure the child attends consistently. As a result the child is behind academically.

Determination: Unfounded **Date of Determination:** 06/15/2016

Basis for Determination:
According to the Saratoga Co. DSS there was no evidence to support that the biological mother was abusing prescription drugs or unable to adequately care for her thirteen-year-old child. It was found that the thirteen-year-old child had been attending tutoring consistently since February and it was only recently that concerns surfaced regarding his attendance which was contributed to medical and transportation issues and had no impact on his grades. During the course of the investigation concerns regarding the thirteen- year-olds need for mental health counseling was identified and learned that the mother had not followed through with past recommendations,therefore SCDSS opened a FSI stage.

OCFS Review Results:
During the review of the 4/8/16 CPS investigation it was discovered that SCDSS made a determination regarding the allegations against the mother and opened the case for services on 6/15/16, however based on the review of the case, an application for an FSI was completed, however the case was never opened in a FSS stage. As a result there was not a FASP or appropriate tracking of the case which is otherwise required. In the FSI stage progress notes were discovered dated from 7/8/16- 8/15/16. Based on the caseworkers notes there was reasonable cause to suspect, however a report was not made. On 8/15/16 a subsequent report was received related to the fatality of the thirteen-year-old child.

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

Issue:
Mandated reporters did not report potential abuse or maltreatment of a child

Summary:
On 6/15/16 SCDSS opened the FSI stage in order to ensure the parent complied with mental health treatment pertaining to the subject child. Based on the caseworker's progress notes found in the FSI stage from 7/8- until the time of the fatality there was reasonable cause to suspect, however SCDSS failed to make a report to the SCR.

Legal Reference:

SSL 413 and 415

Action:

When there is a resonable cause to suspect SCDSS is required to make report to the SCR. SCDSS is expected to develop and implement a protocol that includes the assessment of new information obtained during contact with the family including during the assessment period of service needs.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
10/15/2015	Deceased Child, Male, 12 Years	Mother, Female, 39 Years	Parents Drug / Alcohol Misuse	Unfounded	No
	Deceased Child, Male, 12 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unfounded	

Report Summary:

The report alleged that the mother has significant physical and mental health issues that recently has impacted her ability to care for her twelve- year -old child. Its alleged that the mother mixes her medications and becomes incoherent and volatile as a result.

Determination: Unfounded | **Date of Determination:** 12/28/2015

Basis for Determination:

According to the SCLDSS findings there was insufficient evidence to support that the mother abused her prescription medications and was unable to provide adequate care for her child. An incident between the mother and adult sibling occurred on 10/14/15 , however the child was not present at the time. Due to the incident the adult sibling has made plans to move out of the family residence. The tweleve-year-old child denied any drug or alcohol misuse by the mother. On 12/28/15 the allegations of Inadequate Guardianship and Parents Drug/Alcohol Misuse was unsubstantiated and the case was closed.

OCFS Review Results:

No concerns identified with the investigation.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/10/2015	Deceased Child, Male, 11 Years	Mother, Female, 38 Years	Inadequate Guardianship	Indicated	No
	Deceased Child, Male, 11 Years	Stepfather, Male, 39 Years	Inadequate Guardianship	Indicated	
	Deceased Child, Male, 11 Years	Stepfather, Male, 39 Years	Lacerations / Bruises / Welts	Indicated	
	Deceased Child, Male, 11 Years	Stepfather, Male, 39 Years	Choking / Twisting / Shaking	Indicated	

Report Summary:

Allegations of Inadequate Guardianship, choking an Lacerations/ Bruises/ Welts were indicated against the step father and Inadequate Guardianship against the mother in regards to the eleven- year old subject child. There was evidence found to support ongoing domestic violence in the presence of the child. In addition on 2/9/15 there was an incident in which the step father choked and punched the eleven- year old subject child several times during the course of the incident resulting in visible marks on the child. During the incident the mother was present and failed to intervene and failed to contact Law Enforcement in fear of the step father being arrested.

Determination: Indicated	**Date of Determination:** 04/29/2015
Basis for Determination: The SCLDSS determined sufficient evidence to support allegations against the step- father and mother in regards to the eleven year old subject child. The child sustained visible injuries and family members statements were found to be consistent in regards to the alleged incident. The step- father moved out of the residence. The family was offered Prevention Services, but declined.	
OCFS Review Results: N/A	
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No	

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

There were three reports involving the deceased child, sibling, biological mother/biological father and or step father that were more than three years prior to the fatality.
On 2/9/05 a report was received by Saratoga report alleged ongoing Domestic Violence in the presence of children ages nine and two-years-old. Allegations of Inadequate Guardianship was indicated against the biological father related to both children. In addition, allegations of Inadequate Food/Clothing/ Shelter, Malnutrition, Failure to thrive and Lack of Supervision against both biological parents were unfounded and the case was closed on 8/2/05 with no services recommended. The bio-mother obtained an Order of Protection from Saratoga Family Court and relocated with her children.
On 4/1/11 a report was received by Saratoga County DSS followed by a subsequent report dated 4/5/11. Allegations of Educational Neglect, Inadequate Food/ Clothing/Shelter and Inadequate Guardianship were unfounded against the biological mother and step father in regards to the children ages six and fourteen- years- old. The case was closed on 5/27/11 with no services recommended.
On 6/19/12 a report was received by Saratoga County DSS. The report alleged Educational Neglect and Inadequate Guardianship, against the biological mother and step father in addition to Poisoning/Noxious Substance against the step father in regards to the nine-year-old subject child. Allegations were unfounded and the case was closed on 7/16/12.

Known CPS History Outside of NYS

N/A

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 06/15/2016

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

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? There was no FSS stage opened, therefore requirements such as a FASP did not exist.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☐	☒	☐	☐
Was the FASP consistent with the case circumstances?	☐	☒	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☒	☐	☐	☐

Required Action(s)

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

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

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

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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 hotline report was received on 4/8/16 and was unfounded on 6/15/16. Saratoga County DSS offered voluntary preventive services to the mother which she accepted, an FSI was opened to complete a full assessment of the mother's needs. The caseworker was working with the mother to assist in getting Kyle into mental health counseling to deal with his school anxiety. During this time both mom and Kyle attended appointments with mental health and medical professionals. The various professionals involved with the family who are also mandated reporters did not find reasonable cause to suspect existed and therefore did not make a hotline report.
Saratoga County DSS takes our role very seriously regarding mandated reporter responsibilities. Saratoga County DSS staff are very diligent and competent in their responsibility to report when they feel there is reasonable cause to suspect and in fact over the course of years have made numerous reports when they have felt it warranted.

And in this case, the Caseworker did not feel in her judgment that Reasonable Cause to Suspect existed. In this case, the mother was working with the caseworker on a voluntary basis and in the caseworkers' judgment and based upon her discussion with the professional with whom she consulted she felt the mother was making appropriate efforts to seek the recommended counseling.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☒Yes ☐No

Action:	On 6/15/16 the allegations of a CPS investigation were unfounded, however during the course of the investigation SCDSS had identified service needs resulting in an FSI being opened for ongoing monitoring in order to ensure that the subject child received recommended mental health treatment. During the period of 7/8 - 8/15 SCDSS conducted home-visits and spoke with collaterals. Based on the caseworkers progress notes the parent failed to comply with strong recommendations pertaining to the subject child's mental health treatment which placed the subject child at risk.

Are there any recommended prevention activities resulting from the review? ☒Yes ☐No

Explain: Although a FSI is occasionally used for an assessment of service needs, in this instance service needs had already been identified due to prior investigation that led to the opening of the FSI. There is concerns that a FSI stage was opened for a period of two months while SCDSS continued to monitor the families compliance related to the subject child's mental health treatment. During at which time the fatality occurred. In moving forward it's recommended that the SCDSS review their current practice and discuss the balance between the engagement of the family verses whether legal authority exist. The review of the definition of legal authority and the duration in which a FSI stage remains open for assessment needs to be further evaluated.

In addition, fatality progress notes were found in the FSI stage which raised concerns of confidentiality. All progress notes pertaining to the fatality investigation should only be located in Connections.