Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-20-056

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

Issue Date: Jun 03, 2021

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: 13 year(s)
Jurisdiction: St. Lawrence
Gender: Male
Date of Death: 12/13/2020
Initial Date OCFS Notified: 12/13/2020

Presenting Information

An SCR report alleged on a regular basis, the mother and parent substitute verbally berated and degraded the 13-year-old subject child. On at least one occasion, the parent substitute instructed the child to commit suicide and told him that no one would care. The mother called the child demeaning names and told him he was worthless. The pattern of behavior had a significant emotional impact on the child that ultimately culminated in the child committing suicide in the woods on 12/13/20. The roles of the father and the 7-year-old sibling were unknown.

Executive Summary

This fatality report concerns the death of the 13-year-old male subject child that occurred on 12/13/20. The death was reported to the SCR on 12/15/20 and the report was subsequent to an open investigation regarding concerns about the child's mental health. At the time of the child's death, he resided with his mother and 7-year-old sibling. The mother's partner frequently stayed with the family. The child had siblings who shared the same father and they resided outside of the home. The 7-year-old sibling was assessed to be safe in the care of his parents; however, the record did not reflect an assessment of the siblings who resided outside of the home.

St. Lawrence County Department of Social Services (SCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. Law enforcement responded to a 911 call the mother made prior to the child's death and an officer located the child hanging from a tree stand with a lasso around his neck. The child was lifeless and declared deceased at the scene. Law enforcement did not find the mother, or her partner were responsible for the child's death and law enforcement did not have concerns for the care of the 7-year-old sibling. According to law enforcement, an autopsy was not performed as it was evident the child died as a result of asphyxiation due to full suspension hanging.

Prior to the fatality, the father voiced concerns the mother was not providing the child with adequate mental health services and the child expressed he had suicidal ideations. In September 2020, the father received a text message from the child stating he may hurt himself if he had to stay with the mother. Two months prior to the child's death, the child emailed a schoolteacher saying he wanted to harm himself and soon thereafter the child was admitted to a psychiatric center where he was treated and discharged.

Information gathered from the mother, her partner, and collateral contacts revealed the child was a Person in Need of Supervision and was monitored by a probation officer. Although the child was under the care of mental health specialists due to behavioral and mental health concerns, the mother, her partner and a family friend who was with the child on the day prior to his death, did not express concerns the child was displaying signs he was suicidal; however, information in the case record noted that the probation officer was aware that the mother's boyfriend told the child "go kill yourself" on at least one occasion. This information came from the siblings who resided outside of the home and the probation officer said the child's girlfriend was also aware the mother's boyfriend told the child to kill himself.

The record reflected the family was offered grief counseling in response to the death. The 7-year-old sibling was referred to the Child Advocacy Center for services. At the time this report was written, the investigation remained open and no determination had been made.

PIP Requirement

SCDSS will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS 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:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** N/A
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The investigation remained open at the time this report was written.

Was the decision to close the case appropriate? N/A

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

Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
The casework activity was not commensurate with case circumstances. SCDSS had information the 16-year-old sibling, who resided outside of the home, may have had suicidal tendencies; however, the record did not reflect he was assessed.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	Although the BF requested the SSs have time to grieve, the record did not note they were interviewed at any point during the investigation. The record did not note the teacher or the SC's friend who both said the SC may be suicidal were contacted.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)

Action:	SCDSS will contact or make diligent efforts to contact relevant collateral sources who may have information relevant to the investigation including siblings and other children.
Issue:	Pre-Determination/Assessment of Current Safety/Risk
Summary:	The father expressed concerns for the 16-year-old sibling yet the record did not reflect that sibling was assessed or that the concerns were explored.
Legal Reference:	18 NYCRR 432.2 (b)(3)(iii)(b)
Action:	SCDSS will prioritize making an adequate assessment of safety and risk to all children in the household and surviving siblings, and continue an ongoing assessment of safety and risk throughout the length of the investigation.
Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	Some progress notes were entered more than 2 months after their event dates.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/13/2020 **Time of Death:** 01:04 PM

Time of fatal incident, if different than time of death: 12:10 PM

County where fatality incident occurred: St. Lawrence
Was 911 or local emergency number called? Yes
Time of Call: 12:08 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? No - but needed
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☒ Absent
- ☐ Asleep
- ☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 1

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	13 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	57 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Other Household 1	Father	No Role	Male	40 Year(s)
Other Household 2	Other Adult - Father of 7-year-old sibling	No Role	Male	41 Year(s)

LDSS Response

On 12/15/20, SCDSS received the fatality report from the SCR, subsequent to an open investigation regarding concerns for the SC's MH. SCDSS was aware of the death prior to receiving the report. SCDSS contacted LE, notified the DA's office of the death and noted a CPS history check. On 12/14/20, the 7yo SS was deemed safe in the care of his father, who he was visiting.

According to LE, the SM called 911 stating she and the SC argued and he went into the woods. The SC wanted to go to a friend's house, but the SC's probation officer previously told the SM that was not a good idea, so the SM told the SC "no" and the SC took off into the woods. LE located the SC, hanging from a tree stand, lifeless. Per the ME, no autopsy was performed as it was clear the SC died of asphyxiation due to full suspension hanging.

A collateral who reported he was a service provider to the SC's friend was interviewed. The friend disclosed to the provider he heard the SM degrade the SC and say he was worthless. The friend said the SM's partner (PS) told the SC to go kill himself and that no one would care. The record did not reflect attempts to interview the SC's friend or the friend's parents.

According to the SM, the SC had a history of mental illness. In October 2020, the SC was evaluated, and it was determined that he was not a threat to himself and it was suggested that he spend time in respite. In October 2020, the SC lied about schoolwork and the SM confronted him and an argument occurred. The SC emailed a teacher and threatened self-harm and LE was called. LE talked to the SC and the SC said he threatened self-harm because the SM likes the 7yo SS more. Soon after, the SC was admitted to a psychiatric center for about 10 days and then went to respite before returning home. On the days prior to the death, the SC acted normally and on 12/12/20, the SC spent time with a family friend. On 12/13/20, the SC was fine until the SM would not let him go to a friend's house. The SC argued with the SM and he left. The SM saw the SC go outside and yelled for him to come back to no avail. The SM called LE asking for help talking to the SC. LE told the SM not to follow the SC into the woods. Soon after LE arrived, she was told the SC was found deceased.

The 7yo SS was interviewed at the CAC on 12/21/20. The SS was at his father's house on the day of the fatal incident and did not have concerns for his safety. The SS did not have information regarding the death.

SCDSS gathered information from the PS, the probation officer (PO), the SC's psychiatrist, a first responder and the family friend who the SC was with on the day prior to his death. The PS corroborated the SM's recollection and added that he did not discipline the SC. The case record reflected the PO was aware that the SM's partner told the SC on at least one occasion to "go kill yourself" and that the source of the information were the SSs who resided outside of the home. The record did not reflect there were follow up conversations to gather additional information. The SC's psychiatrist was

concerned when told the SC had access to a lasso and said it would not have been recommended. The SC did not disclose abuse but did mention the PS lectured him. The family friend said the SC was with him on 12/12/20 and that the SC was happy and did not mention anything concerning. The friend had no concerns for the SM or PS's parenting.

The officer who was first to arrive on scene was told the SC went into the woods with a lasso. The SC would use the lasso to practice being a cowboy. She looked for the SC and found him hanging. She lifted the SC while she took the rope off the SC's neck. The officer reported it was normal for the SC to go into the woods to blow off steam, and the SM did what she could. LE planned to close their case without criminal charges.

At the time this report was written, both investigations remained open.

Official Manner and Cause of Death

Official Manner: Suicide
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
Comments: The death was referred to the Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055888 - Deceased Child, Male, 13 Year(s)	055889 - Mother, Female, 38 Year(s)	DOA / Fatality	Pending
055888 - Deceased Child, Male, 13 Year(s)	055889 - Mother, Female, 38 Year(s)	Emotional Neglect	Pending
055888 - Deceased Child, Male, 13 Year(s)	055889 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Pending
055888 - Deceased Child, Male, 13 Year(s)	055890 - Mother's Partner, Male, 57 Year(s)	DOA / Fatality	Pending
055888 - Deceased Child, Male, 13 Year(s)	055890 - Mother's Partner, Male, 57 Year(s)	Emotional Neglect	Pending
055888 - Deceased Child, Male, 13 Year(s)	055890 - Mother's Partner, Male, 57 Year(s)	Inadequate Guardianship	Pending

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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
School	☐	☒	☐	☐
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:
Notes were not entered timely. There was no documentation the SSs who resided outside of the home were assessed for safety. The record did not reflect the teacher who received the email about the SC's suicidal ideation was contacted.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☒	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☐	☒	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☒	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Explain:
The record reflected the siblings who resided outside of the home had a relationship with the child; however, the record did not reflect the siblings were interviewed.

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The siblings did not need to be removed as a result of the fatality.				

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:
Bereavement services were offered to the family and the 7-year-old sibling was referred to the Child Advocacy Center in response to the death.

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? Yes
Explain:
The 7-year-old sibling was referred to the Child Advocacy Center for counseling in response to the child's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The record reflects the parents and mother's partner were offered grief counseling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

10/02/2020	Deceased Child, Male, 12 Years	Mother, Female, 36 Years	Inadequate Guardianship	Pending	Yes
	Deceased Child, Male, 12 Years	Mother, Female, 36 Years	Lack of Medical Care	Pending	

Report Summary:
An SCR Report alleged on 9/29/20, the child threatened to harm himself. The mother became aware on the same day and did not take action. The mother went to the child and started screaming at him because he reached out for help. The child wanted to harm himself because of the way he was treated by the mother who was very hard on him. The role of the father was unknown.

Report Determination: Undetermined

OCFS Review Results:
The case was initiated timely and the source was contacted. Written notice of the report was provided untimely. Notes were not entered contemporaneously with their event dates. The 7-day Safety Assessment and CPS history check were completed untimely. The record did not include an assessment or interview with the 7-year-old sibling. The record did not include a face-to-face interview with the father. There was a predetermination of safety and risk regarding the child and 7-year-old sibling.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7-day Safety Assessment was completed untimely on 11/13/2020, 35 days late. The Safety Assessment was completed without information regarding the child and sibling's overall safety.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
SCDSS will complete all Safety Assessments in the accordance with regulations.

Issue:
Review of CPS History
Summary:
A CPS history check was completed untimely on 11/6/2020, 33 days late.
Legal Reference:
18 NYCRR 432.2(b)(3)(i)
Action:
Within 1 business day of a report, SCDSS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, SCDSS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

Issue:
Failure to provide notice of report
Summary:
Although the adults were provided with written notice of the SCR report, they were provided with written notice untimely on 11/13/2020, 35 days late.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:

SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Although interviewed over the phone, the record did not reflect the father was interviewed face-to-face regarding the report.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
SCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
The case record contained progress notes entered more than 3 months after their event dates. At the time this report was written, it had been more than 3 months since casework activity was documented.
Legal Reference:
18 NYCRR 428.5
Action:
SCDSS will document all progress notes contemporaneously to their event dates.

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)
Summary:
Although the child was interviewed, the record did not reflect the child was interviewed regarding the specific allegations within the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(d)
Action:
SCDSS will fully explore the extent of what is alleged as it pertains to the safety and risk to the alleged maltreated child.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
Although the parents were interviewed and collateral contacts were made, conflicting information was gathered regarding the child's safety and further information regarding an assessment of safety and risk was not documented. The case record did not reflect an assessment of the safety of the 7-year-old sibling.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
SCDSS will prioritize making an adequate assessment of safety and risk to all children in the household, and continue an on-going assessment of safety and risk throughout the length of the investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/29/2018	Deceased Child, Male, 11 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 11 Years	Mother, Female, 36 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 36 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 11 Years	Mother, Female, 36 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
An SCR report alleged on 11/29/18, around 4:20 PM, the 11-year-old child ran away from home and the child's whereabouts were unknown. The child suffered from depression and suicidal ideation and had a specific plan of harm. The mother was aware, minimized the child's mental health status, and failed to ensure the child took his medication or was properly supervised. The mother left the child and the 5-year-old sibling home alone, unsupervised, for up to 45 minutes. Due to the child's mental health status, he could not be alone for any amount of time or care for the 5-year-old sibling. The child threatened to physically harm himself when the 5-year-old sibling did not listen.

Report Determination: Unfounded **Date of Determination:** 09/30/2019

Basis for Determination:
The allegations of Inadequate Guardianship, Lack of Supervision and Lack of Medical Care were unsubstantiated against the mother for the children. The caseworker interviewed the family and collateral contacts. Although the child ran away, the mother sought assistance in locating the child. The child expressed suicidal ideation to a counselor and the mother had the child psychologically evaluated and the child was admitted to a psychiatric center for approximately 1 month. The mother agreed to not leave the children unsupervised.

OCFS Review Results:
The investigation was initiated and a SCR check was documented timely. The source of the report was interviewed, and other collateral contacts were made. The 7-day Safety Assessment was completed timely. Written notice of the SCR report was provided untimely to the mother and father of the 5-year-old sibling. Written notice was not provided to the father of the child. The father of the child was not interviewed regarding the SCR report. The record did not reflect casework activity from 12/4/18-3/12/19. There was no casework activity from 3/12/19- 9/12/19.

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

Issue:
Failure to provide notice of report

Summary:
Although the mother and father of the sibling were provided with written notice, the father was not provided with written notice of the SCR report.

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

Action:
SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household or added to the case, they will be notified in writing as well.

Issue:
Timely/Adequate Seven Day Assessment

Summary:
Although accurate, the 7-day Safety Assessment was completed untimely on 12/18/18, 12 days late.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
The results of each Safety Assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day Safety Assessment in Connections.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
The record did not reflect the father was interviewed regarding the SCR report. There was a missed opportunity to obtain information from the father, who may have had information pertinent to the investigation.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
SCDSS will make efforts to make casework contacts with biological parents and/or persons named in a report.

Issue:
Pre-Determination/Assessment of Current Safety/Risk
Summary:
The record did not reflect casework contact took place from 12/4/18 until 3/12/19 or from 3/12/19 until 9/12/19. Therefore, there was not an ongoing assessment of safety and risk regarding the children.
Legal Reference:
18 NYCRR 432.2 (b)(3)(iii)(b)
Action:
SCDSS will prioritize making an adequate assessment of safety and risk to all children in the household and continue an ongoing assessment of safety and risk throughout the length of the investigation.

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

11/29/11- 2/10/12- The mother and father of the 7-year-old sibling were unsubstantiated for the Inadequate Guardianship, Lacerations/Bruises/Welts, and Swelling/Dislocations/Sprains against the sibling.

11/8/16- 1/17/17- The father of the 7-year-old sibling was unsubstantiated for the Inadequate Guardianship of the sibling.

Known CPS History Outside of NYS

There was no known CPS history outside of New York.

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

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