Child Fatality Report

Report Identification Number: BU-22-013

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

Issue Date: Nov 28, 2022

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	DA-District Attorney	
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	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 06/23/2022
Initial Date OCFS Notified: 06/23/2022

Presenting Information

On 6/23/2022, Erie County Department of Social Services (ECDSS) reported the death of the 17-year-old male child to the Office of Children and Family Services via the 7065 Agency Reporting Form. The child was found by his sister to have committed suicide by hanging, sometime prior to 1:00 AM on 6/23/2022. There was an open CPS investigation with the family at the time of the child's death. The CPS investigation began after the death of the child's grandmother, who was also his custodian. ECDSS was providing services to the child and his adult sister after the grandmother's death. There were no surviving siblings under the age of 18 and no other children residing in the home.

Executive Summary

This report regards the death of the 16-year-old male subject child, which occurred on 6/23/2022. At the time of his death, the subject child resided with his 18-year-old adult sibling. The subject child and his sibling had been in the custody of their maternal grandmother since 2006, until her death on 5/19/2022. The mother of the subject child lived out of state and had infrequent contact with the child. The father of the subject child was deceased.

ECDSS had received an SCR report on 5/20/2022, with allegations that the maternal grandmother died and there was no appropriate caretaker for the subject child. ECDSS assessed the subject child to be safe in the care of his adult sibling, who reported she planned to petition for custody of the subject child. ECDSS spoke with the mother, who reported she was agreeable to the subject child remaining in the care of his adult sibling.

On 6/23/2022, ECDSS was contacted by the subject child's school and a school staff member informed ECDSS that the subject child was deceased and was believed to have committed suicide. ECDSS contacted the office of the Medical Examiner and learned the subject child had died by what appeared to be a self-inflicted hanging and there was no foul play suspected. ECDSS requested and received records from law enforcement which note emergency services were contacted at 1:09 AM on 6/23/2022 and responded to the family's home for a reported suicide attempt. Upon arrival, law enforcement found the subject child deceased.

As the death of the subject child was not reported to the SCR, there were no allegations related to the fatality to be determined. The case open at the time of the subject child's death was unfounded for Inadequate Guardianship regarding the subject child; however, the SCR report specified that the allegation was registered against an "unknown person" as it reflected that the custodial grandmother died leaving no appropriate caretaker for the subject child. ECDSS noted in the investigation determination that the allegation was unsubstantiated as the "unknown person" did not exist.

After the death of the subject child, ECDSS referred the adult sibling to bereavement services via email. The biological mother contacted ECDSS to request monetary assistance for burial and ECDSS referred the mother to contact her local department of social services as she was out of state. The record did not reflect that ECDSS referred the adult sibling to burial services.

PIP Requirement

This review resulted in a citation related to casework practice. In response, ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the ECDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, ECDSS will review the plan(s) and revise as needed.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
There was minimal detail documented regarding the child's death. Based on the information ECDSS gathered, they determined there was no reasonable cause to suspect the death was a result of abuse or maltreatment. ECDSS closed their investigation following the subject child's death, though the record did not reflect whether the adult sibling was provided appropriate services related to the fatality.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
The death of the subject child was not reported to the SCR; therefore, safety assessments and a determination were not required.

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: 06/23/2022 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 06/22/2022

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Erie

Was 911 or local emergency number called? Yes

Time of Call: 01:09 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ 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	Adult Sibling	No Role	Female	18 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	16 Year(s)

LDSS Response

ECDSS initiated an investigation upon receipt of the SCR report that was open at the time of the fatality. ECDSS coordinated with the family and visited a relative's home on 5/20/2022 to interview the subject child. The subject child reported he did not wish to move out of state to live with his mother, with whom he had little contact, and stated he preferred to stay with his adult sibling in the home of their recently deceased grandmother. ECDSS spoke with the subject child, the adult sibling, and the mother, all of whom agreed they would work together to provide for the subject child's needs.

Upon his initial interview on 5/20/2022, the subject child disclosed that he had not been to school for "a couple of weeks" as he had been staying home to care for his ailing grandmother. The record reflects ECDSS did not contact the subject child's school to discuss his school attendance and performance, despite the child's age mandating his compulsory school attendance. ECDSS's first contact with the subject child's school occurred on 6/23/2022, when school staff contacted ECDSS to report they had learned of the subject child's death. No further information from the school was documented.

In the days prior to the subject child's suicide, ECDSS received a voice-mail message from the adult sibling. In the message, the sibling disclosed she would not be filing for custody of the subject child, as they felt they were unable to control the subject child's behaviors. The adult sibling further reported the subject child had been talking about suicide, had threatened to harm himself, and had harmed himself. The record reflected after ECDSS received the voice-mail message, a discussion took place with the adult sibling on 6/22/2022; however, the record does not reflect any discussion between ECDSS and the adult sibling regarding safety planning pursuant to the subject child's suicidal ideation or self-harm.

After speaking with the adult sibling, ECDSS contacted the out-of-state mother via telephone to explain she was responsible for the care and safety of the subject child as she was his mother and had never lost her parental rights. During that phone conversation with the mother, ECDSS was informed the subject child had learned that a plan was made for the mother to come to NYS to take custody of him, and the child's response was that he would rather die than go to live with his mother. ECDSS asked the mother whether she believed the subject child would need to be evaluated due to his mental

health concerns and provided contact information for emergency mental health services; however, the mother reported she was unsure if the subject child's threats to harm himself were genuine or the result of his unwillingness to move out of NYS.

ECDSS learned of the subject child's suicide on the morning of 6/23/2022. The record does not reflect any information regarding the circumstances of the subject child's death was gathered from the adult sibling, the mother, or any other family member.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team?No

CPS Fatality Casework/Investigative Activities

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

Additional information:
Records were gathered from law enforcement; however, those records contained minimal information. There was no follow-up contact with law enforcement, EMS, or other first responders.

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☐	☐	☒	☐	☐	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☒	☐	☐	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

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)
05/20/2022	Deceased Child, Male, 16 Years	Other - Unknown Adult, Unknown, 59 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
The SCR report alleged the maternal grandmother had custody of the 16-year-old subject child and she passed away suddenly on 5/19/2022. An 18-year-old sibling resided in the home; however, the report alleged that the sibling did not have the maturity to care for the subject child. There were no other appropriate adults to care for the subject child. As the grandmother was deceased and there were no other caretakers available, an "unknown adult" was added to the report so that it could be registered by the SCR, to enable ECDSS to provide services for the subject child pursuant to the passing of his grandmother.

Report Determination: Unfounded | **Date of Determination:** 06/28/2022

Basis for Determination:
ECDSS noted the adult sibling initially planned to petition for custody of the subject child; however, later decided she could not do so, due to the demands of her work schedule and her inability to control the subject child's behaviors. The subject child had inflicted harm on himself and expressed suicidal ideation, prompting a plan to be made on 6/22/2022, that the biological mother, who lived out of state, would travel to NY to take custody of the subject child. On 6/23/2022, around 1:00 AM, the adult sibling found the subject child to have committed suicide by hanging. The reported allegations of Inadequate Guardianship were unsubstantiated as they referred to a non-existent subject.

OCFS Review Results:
ECDSS's response to the reported allegations, and to further concerns which arose during the investigation, was critically lacking. The record does not reflect an attempt to gather records from pertinent collaterals such as schools, medical professionals, or mental health professionals. ECDSS was made aware of significant concerns for the subject child's mental health, including suicidal ideation and self-harm, on 6/19/2022; however, the record does not reflect those concerns were discussed with the adult sibling. Safety planning was discussed with the mother who resided out of state, and not with the adult sibling, who was the caretaker for the child at the time.

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

Issue:
Overall Completeness and Adequacy of Investigations

Summary:
The investigation was lacking in multiple areas. Critical safety concerns disclosed to ECDSS by the adult sibling were not adequately addressed and pertinent collaterals were not contacted. Furthermore, the risk for the subject child was not adequately addressed and the Risk Assessment Profile lists the deceased maternal grandmother as the only caretaker for the child.

Legal Reference:
SSL 424.6 and 18 NYCRR 432.2(b)(3)

Action:
ECDSS will review and adhere to regulations regarding casework practice in general. OCDSS will make collateral and familial contacts, address all potential areas of concern with all relevant parties, and adequately monitor any on-going concerns when it is necessary to remain involved.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/23/2021	Deceased Child, Male, 15 Years	Grandparent, Female, 57 Years	Childs Drug / Alcohol Use	Unsubstantiated	No
	Deceased Child, Male, 15 Years	Grandparent, Female, 57 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 17 Years	Grandparent, Female, 57 Years	Childs Drug / Alcohol Use	Unsubstantiated	
	Sibling, Female, 17 Years	Grandparent, Female, 57 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 15 Years	Grandparent, Female, 57 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
The SCR report alleged the custodial grandmother had left the then 17-year-old sibling as the sole caretaker of the then 15-year-old subject child. The sibling was not mature enough to care for the subject child, who had a history of physical aggression and mental health issues. Furthermore, the report alleged the sibling and subject child were able to use illegal substances and recklessly drive while unsupervised.

Report Determination: Unfounded | **Date of Determination:** 05/06/2021

Basis for Determination:
When interviewed, the subject child and sibling admitted to marijuana use for themselves and reported they used marijuana with their grandmother. During a home visit, ECDSS noted drug paraphernalia in the bedrooms of both children as well as the grandmother. The allegations of Inadequate Guardianship and Child's Drug / Alcohol Misuse were substantiated, while the allegation of Lack of Supervision was unsubstantiated regarding the subject child as it appeared the grandmother did make an adequate plan for the children. An administrative review and fair hearing were completed and the record was amended, with all allegations being unsubstantiated.

OCFS Review Results:
ECDSS conducted an investigation within regulatory guidelines. ECDSS appropriately addressed the reported concerns as well as further concerns uncovered during the investigation. ECDSS referred both children for mental health services and closed the investigation after verifying the children were engaged with the mental health provider.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/15/2019	Deceased Child, Male, 13 Years	Aunt/Uncle, Male, 37 Years	Choking / Twisting / Shaking	Substantiated	No
	Deceased Child, Male, 13 Years	Aunt/Uncle, Male, 37 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 13 Years	Aunt/Uncle, Male, 37 Years	Parents Drug / Alcohol Misuse	Substantiated	

Report Summary:
The SCR report alleged the subject child had been attacked by his maternal uncle. The maternal uncle was intoxicated when he became angry with the subject child and placed his hands around the child's neck, cutting off the child's breathing. The child sustained lasting redness to his neck.

Report Determination: Indicated | **Date of Determination:** 10/28/2019

Basis for Determination:
ECDSS learned through investigation that the grandmother, 2 maternal uncles, the subject child, and the sibling had gone to the beach for the day on 7/14/2019. Upon returning home, the uncles were both intoxicated and began to argue with each other. The subject child attempted to intervene in the argument and the subject uncle attacked him and put his hands around the child's throat. The uncle was arrested and a order of protection was put in place barring the uncle from contact with the subject child. The allegations of Inadequate Guardianship, Parent's Drug / Alcohol Misuse, and Choking / Twisting / Shaking were appropriately substantiated.

OCFS Review Results:
ECDSS completed an investigation that met regulatory guidelines. ECDSS interviewed family members and pertinent collaterals and gathered information to adequately assess for the safety and risk of the subject child and surviving sibling. During the investigation, the subject child was hospitalized twice due to mental health issues and threats to harm himself and ECDSS followed up as appropriate to verify the child was engaged with services prior to closing the investigation.

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

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

The maternal grandmother was the subject of two unfounded SCR reports more than three years prior to the fatality. The reports were received 4/21/2017 and 10/27/2017. Both reports contained allegations of Inadequate Guardianship and Lack of Supervision regarding the subject child and the now adult sibling.

The biological mother and biological father were the subject of one indicated SCR report more than 3 years prior to the fatality. The report was received 5/4/2006, and contained allegations of Inadequate Guardianship and Parent's Drug / Alcohol Misuse regarding the subject child and the now adult sibling. The maternal grandmother filed for and was granted custody of the children during that investigation.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

A Preventive Services Case was opened 01/19/2018, due to concerns the subject child was exhibiting verbally and physically aggressive behaviors at home and at school. Those behaviors resulted in the subject child's suspension from school. The subject child had a history of refusing to take his prescribed mental health medications. The subject child and the custodial grandmother engaged with all referred and recommended services, the child's behaviors improved significantly, and the Preventive Services Case was closed on 10/10/2018.

A Preventive Services Case was opened 6/6/2006, to provide services to the maternal grandmother, the subject child, and the sibling. The grandmother had filed for emergency custody in May 2006 and was granted permanent custody on 6/2/2006. The grandmother appropriately engaged with all services recommended, whereas both biological parents failed to engage with any services. The Preventive Services Case closed on 5/25/2007, and the children remained in the care of the maternal grandmother.

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, accurately describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the actions related to the fatality were conducted appropriately and that there are no required actions related to same. However, we must unfortunately concur with the compliance issue noted by the reviewer with respect to the CPS investigation that was open at the time of the fatality. With respect to the investigation of the SCR report dated May 20, 2022, we acknowledge that the overall completeness and adequacy of the documented investigation was lacking in multiple areas. We note that the open investigation was conducted outside of the scope of the ECDSS CPS Fatality Teams, but discussions with the CPS Coordinator overseeing the investigating team seem to suggest that the failures are more in line with lapses in documentation rather than investigative tasks. For example, the OCFS-7065 submitted to OCFS on June 23, 2022 reflects discussions with the school which are not included in the CONNECTIONS notes. We do recognize, however, that credit cannot be given for tasks not documented. We further note that discussions will be held amongst ECDSS administrators to consider the idea of transferring to one of ECDSS' two Fatality Teams any future open case on which a child death occurs.

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