Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-23-014

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

Issue Date: Sep 05, 2023

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 had an open investigation or a CPS monitored services 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: 12 year(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 05/17/2023
Initial Date OCFS Notified: 05/18/2023

Presenting Information

Erie County Department of Social Services (ECDSS) received a report from the SCR on 5/17/2023 alleging that, while in the care of an unknown guardian, the 12-year-old subject child was found in the bathroom with ligature marks around his neck and no pulse. Further details were unknown.

Executive Summary

This fatality report concerns the death of a 12-year-old male subject child that occurred on 5/17/2023. The SCR report contained allegations of DOA/Fatality, Lacerations/Bruises/Welts, and Inadequate Guardianship against the custodial grandmother regarding the child. At the time of his death, the subject child resided with his grandmother and great-grandfather. The birth parents both resided out of state separately with little to no contact with the subject child. There was one maternal half-sibling who resided out of state with the birth mother and had never met the subject child. The grandmother, great-grandfather, biological mother, and biological father did not have any CPS history.

ECDSS collaborated efforts with law enforcement and learned that on 5/17/2023 the subject child expressed not wanting to go to school that morning to his grandmother when she attempted to wake him up. The subject child ultimately went to school and returned home between 4:30-4:40PM. The subject child went to his bedroom when he first arrived home and then went to the kitchen and ate a snack before disclosing that another child had bullied him to his grandmother. The grandmother was tending to a younger cousin who was at the home visiting during the time the subject tried to initiate a conversation about his day. The subject child played with his young cousins for a short time and then returned to his bedroom. At approximately 8:00PM, the subject child went for a 15-minute bike ride and then returned to his bedroom. A short time later the grandmother heard the cousins yelling and screaming and when she went to address them, she noticed a sock sticking out of the bathroom door. The grandmother attempted to gain entry to the bathroom door but found the door very hard to open. When the grandmother tried to open the door, she noticed that the subject child was inside the bathroom because she saw the child's hand fall to the floor. The grandmother called to the child to ask him if he was okay, and he did not respond. The grandmother phoned the grandfather that did not live in the home, but worked down the street for assistance. The grandfather arrived immediately and opened the bathroom door, and the subject child was observed to have very pale white skin. The grandfather attempted CPR and 911 was called immediately. Emergency medical services continued life-saving efforts and the child was transported to the hospital where he was pronounced deceased.

An autopsy was performed, and the manner of death was listed as suicide caused by hanging. The medical examiner noted there was no evidence of abuse or neglect. Law enforcement conducted a criminal investigation regarding the death of the child; however, the record did not reflect an update on their investigation at the time this report was written. There was documentation that law enforcement did not feel the grandparents had anything to do with the death.

ECDSS unsubstantiated the allegations of DOA/Fatality, Lacerations/Bruises/Welts and Inadequate Guardianship against the grandmother. ECDSS determined there was no evidence of abuse or neglect against the grandmother. The CPS investigation was unfounded and closed on 7/12/2023. ECDSS offered the family bereavement services, but it was unknown if burial assistance was offered.

PIP Requirement

ECDSS will submit a PIP to the Buffalo Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ECDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented,

ECDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

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

Determination:

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

Explain:
The determination was made in congruence with the evidence gathered and the safety assessment at the time of determination was appropriate.

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:
There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	ECDSS documented in the progress notes that the secondary caretaker had a cognitive impairment that was known to progress over time but did not reflect this within the RAP, particularly risk element 11.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ECDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/17/2023 **Time of Death:** Unknown

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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	Deceased Child	Alleged Victim	Male	12 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	54 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	80 Year(s)

LDSS Response

Upon receipt of the SCR report on 5/17/2023, ECDSS initiated their response within 24 hours and coordinated their investigation with law enforcement. ECDSS spoke with collateral sources, completed a history check, interviewed family members and conducted multiple home visits. There was a surviving maternal half-sibling who lived out of state with the birth mother that did not have a relationship with the subject child.

ECDSS interviewed the PGM at the home and learned that on 5/17/2023, the grandmother went to wake the SC for school that morning and the SC expressed not wanting to go to school. The SC eventually got up and got ready for school and left the home. The PGM received a phone call from school staff at approximately 3:20PM reporting that there was a bullying incident that day at school and the target was the SC. The SC returned home between 4:30-4:40PM and had a bowl of cereal as his usual routine and then ate dinner with the paternal great-grandfather (PGGF) a short time later. After eating dinner, the SC went to his room which was normal; however, he did not play the PlayStation which he did routinely play after school. The SC placed his computer monitor face down which the PGM reported as odd. The SC came out of his room and attempted to engage the PGM in conversation by telling her that there was another student at school that day who had bullied him. The PGM was distracted during this time by younger cousins, ages 4 and 9 years old, visiting the home. The PGM then checked on the SC around 6:00PM and he was in his room playing on his cell phone. The SC came

out of his bedroom and started to play with his cousins before returning to his bedroom. At approximately 8:00PM the SC went for a 15-minute bike ride and then returned to his bedroom. The PGM walked past the bathroom a short time later and noticed what looked like a sock sticking out of the door. The PGM tried to open the door which would not open all the way and saw the SC's hand fall near the doorway. The PGM used the phone and called the PGF, who did not live in the home but worked down the street, to see if he could help open the bathroom door. The PGM asked the SC if he was okay several times and he did not respond. The PGF and a co-worker arrived immediately and opened the bathroom door to find the SC very pale white and unresponsive. The PGF's co-worker called 911 and the PGF initiated CPR. EMS arrived within minutes and continued life-saving efforts for approximately 40 minutes at the home. The SC had used a flat iron cord to hang himself via a rack on the back of the bathroom door, ligature marks were observed on his neck. The SC was then transferred to the hospital where he was pronounced deceased. ECDSS attempted to interview the PGGF but was unsuccessful due to a progressing cognitive impairment.

ECDSS learned through records and interviews that the SC had been a target of bullying at his school and on social media platforms from his peers at school. The GMA and GFA attempted to address the issue multiple times and felt not enough was done to address the situation. The GMA and the GFA went to the school on 1/23/2023 to speak with the principal regarding the bullying; however, were unsuccessful and were advised that someone from the school would reach out to them and that did not happen. A school staff, who had advocated for the SC, reported having kept a diary of the incidents happening at school. It was unclear the steps that were taken by the school to address the issue as they refused to cooperate with ECDSS during the investigation. The GMA reported the SC did not act strange or out of the ordinary the days leading up to the incident and there was no suicide note left.

The autopsy report listed the cause of death as suicide and the manner of death as hanging. There were no signs of abuse or neglect. The SC had been seen by his pediatrician routinely with no concerns for his care noted

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 referred to an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064428 - Deceased Child, Male, 12 Yrs	064525 - Grandparent, Female, 54 Year(s)	DOA / Fatality	Unsubstantiated
064428 - Deceased Child, Male, 12 Yrs	064525 - Grandparent, Female, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
064428 - Deceased Child, Male, 12 Yrs	064525 - Grandparent, Female, 54 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
ECDSS interviewed the birth mother and father over the phone due to them both residing out of state.

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ECDSS offered the family bereavement services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

ECDSS requested history from out of state areas where the family was known to have lived previously. Those areas reported having no CPS history related to the subject child, PGM or PGGF.

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 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. With regard to the citation related to the fatality investigation, we must unfortunately concur with the reviewer's finding that the secondary caretaker's cognitive impairment was not reflected on the RAP. We do, however, note that recording the secondary caretaker's cognitive impairment on the RAP would not have affected the risk rating of the RAP in a substantial way and that, as a practical matter, the identified secondary caretaker appears to have had little to no actual caretaking responsibility for the child. As a corrective action measure, we have reviewed and addressed the matter with the investigating caseworker and the approving supervisor.

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