Child Fatality Report

Report Identification Number: SY-23-010

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

Issue Date: Aug 08, 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
Jurisdiction: Onondaga
Date of Death: 02/25/2023
Age: 17 year(s)
Gender: Male
Initial Date OCFS Notified: 02/27/2023

Presenting Information

The SCR report alleged the subject child had a history of depressed mood. On multiple occasions the subject child told his parents he was going to kill himself. The parents failed to access crisis or mental health services for the subject child. On 2/11/23, the subject child hanged himself in the garage of the home at approximately 3:15PM. 911 was contacted and emergency medical services responded to the home at 3:28PM. Emergency medical services were able to resuscitate the subject child; however, he was not conscious and was not able to breathe on his own again. On 2/25/23, the subject child was removed from life support and was pronounced deceased at the hospital at 4:19PM. The role of the surviving sibling was unknown.

Executive Summary

This fatality concerns the death of the 17-year-old male subject child that occurred on 2/25/23. The SCR report contained allegations of Inadequate Guardianship, Lack of Medical Care, and DOA/Fatality against the mother and father. At the time of his death, the subject child resided with his mother, father, and 13-year-old surviving sibling.

Onondaga County Department of Children and Family Services (OCDCFS) completed casework and collateral contacts and learned that on 2/11/23, while on Facetime with his girlfriend, the subject child hanged himself in the family's garage with an electrical cord. The subject child's girlfriend contacted 911 and emergency medical services responded to the residence. The subject child was resuscitated but remained unconscious at the hospital, could not breathe on his own, and was removed from life support on 2/25/23.

The family requested an external examination of the subject child that concluded there were no residual marks on the subject child's neck or blunt impact injuries; however, it was noted there was Diffuse Anasarca. The final cause of death was listed as Diffuse Axonal Injury Complicating Hanging and the manner was determined to be suicide. There were no criminal charges filed regarding the death of the subject child.

Bereavement services were declined by the family. The sibling was receiving support from friends and her school counselor and reported she did not want to engage with any other counselor or therapist. The mother was utilizing counseling services through her employer. The allegations of the report were unsubstantiated against the mother and father, as it was noted the mother and father had previously attempted to get the subject child mental health counseling, but he refused. The sibling was deemed to be safe in the care of the mother and father. The case was unfounded and closed on 5/17/23.

PIP Requirement

For citations identified in historical cases, OCDCFS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDCFS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDCFS 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?** Yes
- **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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
OCDCFS made an appropriate determination based on evidence obtained during their investigation.

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:
Casework was commensurate with case circumstances.

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: 02/25/2023 **Time of Death:** 04:19 PM

Date of fatal incident, if different than date of death: 02/11/2023
Time of fatal incident, if different than time of death: 03:15 PM

County where fatality incident occurred: Onondaga

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? Unknown
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Facetiming his girlfriend

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	17 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	66 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	56 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDCFS completed a home visit, assessed the safety of the SS, interviewed the SM and SF, completed a CPS history check, and contacted collateral sources.

OCDCFS interviewed the SM, SF, and obtained information from LE regarding the events preceding the SC's death. The SF reported on 2/10/23, the SC's girlfriend came over to the family's residence. The SC brought his girlfriend home that evening and when he returned, the SF stated the SC was in a bad mood. The SF did not speak to the SC that night and stated when the SC is in that mood, he gives him space and tells him to talk when he is ready. LE reported the SF texted the SC that night and the SC told the SF to leave him alone because he was going "through something." On 2/11/23, the SC went to work but was sent home due to being in a bad mood and not working productively. The SC sent his girlfriend a photo text message of a noose; however, in a statement to LE, the girlfriend reported she did not see the photo for approximately 30 minutes. When the SC's girlfriend did see the photo, she immediately called the SC on Facetime. The SC stated to his girlfriend that "things are not changing; things are not getting better." The SC then propped his cellphone up while still on Facetime and hanged himself by the neck with an electrical cord in the family's garage. The SC's girlfriend texted 911 while on Facetime with the SC. The SC stopped responding to his girlfriend while on Facetime and 911 called the girlfriend, who stated the SC was unresponsive at that time. EMS responded to the home and were able to resuscitate the SC; however, he was unconscious and could not breathe on his own. The SC was removed from life support and pronounced deceased at the hospital on 2/25/23.

The SC's girlfriend told LE the SC had a history of MH concerns and that the SC was in a bad mood all day, and even asked his girlfriend for help earlier in the day because his MH had become so bad. The SC's girlfriend stated the SC had previously talked about killing himself.

The SF stated he thought the SC was downstairs in his bedroom, as he heard music playing. The SF stated he took a nap and woke up to LE and EMS in his home. The SM stated she was usually always home with the SC but had left with the SS to go to the library for an hour to an hour and a half on the day of the incident. The SF stated the SC's girlfriend attempted to contact the SM and SF; however, the SF did not have his phone and the SM was at the library at the time.

The family's CPS history revealed that in 2016 the SC made suicidal comments to friends, though it was not believed the SC was in MH treatment at that time. The family's prior CPS involvement also reflected the SC's history of high risk behavior including substance misuse, truancy, and vandalism. The SM and SF stated they attempted to get the SC into counseling, but the SC refused. The SM and SF reported the SC took Adderall due to being diagnosed with attention-deficit/hyperactivity disorder (ADHD); however, denied the SC had other MH diagnoses. The SF reported the SC did not take his prescribed medication as directed and would often not take the medication at all or take too much. The SC previously stated he wanted to fully feel the effect of the medication. The SC's school counselor denied having concerns regarding the SC's MH or being aware of any suicidal comments or ideation.

The parents denied any MH concerns for the SS and reported the SS was being monitored by the pediatrician regarding grief related to the SC's death; however, the record did not reflect this was confirmed with the pediatrician. The SS was deemed safe in her parents' care.

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
Comments: Onondaga County referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064509 - Deceased Child, Male, 17 Yrs	064510 - Mother, Female, 56 Year(s)	DOA / Fatality	Unsubstantiated
064509 - Deceased Child, Male, 17 Yrs	064510 - Mother, Female, 56 Year(s)	Inadequate Guardianship	Unsubstantiated
064509 - Deceased Child, Male, 17 Yrs	064510 - Mother, Female, 56 Year(s)	Lack of Medical Care	Unsubstantiated
064509 - Deceased Child, Male, 17 Yrs	064511 - Father, Male, 66 Year(s)	DOA / Fatality	Unsubstantiated
064509 - Deceased Child, Male, 17 Yrs	064511 - Father, Male, 66 Year(s)	Inadequate Guardianship	Unsubstantiated
064509 - Deceased Child, Male, 17 Yrs	064511 - Father, Male, 66 Year(s)	Lack of Medical Care	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?	☒	☐	☐	☐

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?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine

Was the risk assessment/RAP adequate in this case?	X			
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	X			
Was there an adequate assessment of the family's need for services?	X			
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?		X		
Were appropriate/needed services offered in this case	X			

Explain:
OCDCFS offered services to the family but they were declined.

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?		X		
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?		X		

Explain as necessary:
The SS was assessed to be safe in the care of the parents and therefore, no removal was necessary.

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		X					
Economic support						X	
Funeral arrangements				X			
Housing assistance						X	
Mental health services		X					
Foster care						X	
Health care						X	
Legal services						X	
Family planning						X	

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:
OCDCFS offered bereavement services to the parents and on behalf of the SS; however, they were declined. The record did not reflect that burial assistance was offered to the parents.

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? No
Explain:
OCDCFS offered services on behalf of the SS; however, they were refused. The SM reported the SS had been evaluated by the pediatrician regarding her MH and grief following the SC's death, though the record did not reflect this was confirmed. The SC was receiving support through friends and her school counselor, though the school recommended the SS receive additional counseling services. The SS reported she did not want to talk to any other counselors or therapists.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Bereavement services were offered to the SM and SF, but the family declined. The SM was utilizing counseling services through her employer and was in contact with a counselor.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)
01/27/2022	Deceased Child, Male, 16 Years	Mother, Female, 55 Years	Lack of Supervision	Far-Closed	Yes
	Sibling, Female, 12 Years	Mother, Female, 55	Inadequate	Far-Closed	

	Years	Guardianship	
Sibling, Female, 12 Years	Mother, Female, 55 Years	Lack of Supervision	Far-Closed
Deceased Child, Male, 16 Years	Mother, Female, 55 Years	Inadequate Guardianship	Far-Closed
Deceased Child, Male, 16 Years	Father, Male, 65 Years	Lack of Supervision	Far-Closed
Sibling, Female, 12 Years	Father, Male, 65 Years	Lack of Supervision	Far-Closed
Deceased Child, Male, 16 Years	Father, Male, 65 Years	Inadequate Guardianship	Far-Closed
Sibling, Female, 12 Years	Father, Male, 65 Years	Inadequate Guardianship	Far-Closed

Report Summary:
The SCR report alleged the SM and SF did not adequately supervise the SC and SS. The SM and SF left the CHN home alone, unsupervised, for weeks and up to a month at a time when they left the country. The SM and SF were not able to be contacted while they were gone, and they did not provide a contact for someone who could be called in the event of an emergency. When left unsupervised, the CHN did not go to school consistently and on at least one occasion, the SC had accessed and consumed alcohol and had intercourse with a female he invited to the home.

OCFS Review Results:
OCDCFS initiated their investigation within 24 hours, completed a CPS history review, interviewed household members, and made collateral contacts. The 7-Day Safety Assessment was completed late on 2/7/23. The SCR report was tracked as FAR, despite a corresponding Law Enforcement Referral with allegations of SA.

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 late on 2/7/23.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
OCDCFS will document and approve all safety assessments within the required time frame.

Issue:
FAR-Inappropriate Determination of CPS/FAR Track
Summary:
Although the SCR report did not contain allegations of SA, a Law Enforcement Referral (LER) was received at the time of the initial intake report that alleged SA. Despite the alleged SA and corresponding LER, the report was tracked as FAR. OCDCFS did not coordinate with LE until 2/7/22.
Legal Reference:
18 NYCRR 432.13 (c); 18 NYCRR 432.13(e)(2)(ii)(a-d)
Action:
OCDCFS will review and adhere to regulations regarding FAR practice and casework practice in general.

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

There was an indicated report from 4/2016 for IG and L/B/W against the SM and SF. The SF struck the SC with a

keyboard after an argument which resulted in marks to the SC's back. There was additional concern regarding the SS being locked in her room for the entirety of the day. A safety plan for no violence and age appropriate discipline was put in place. The SF underwent a MH evaluation but was not recommended for treatment. There was one FAR case in 6/2016 regarding concern for the supervision of the SC and SS.

Known CPS History Outside of NYS

There was no known history outside of New York State.

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