Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-18-001

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

Issue Date: Jun 15, 2018

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		

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Tompkins
Gender: Male
Date of Death: 12/19/2017
Initial Date OCFS Notified: 01/02/2018

Presenting Information

On 12/21/2017, the death of the SC was reported to OCFS by the Tompkins County Department of Social Services (TCDSS) through the required Agency Reporting Form 7065 because TCDSS had an open Preventive Services case with SC and his BM at the time. On 12/19/2017, SC was in the road and was struck by a vehicle and killed.

Executive Summary

On 12/20/2017, TCDSS was notified that SC passed away the night prior from injuries sustained after being struck by a vehicle. TCDSS had an open Preventive Services case involving SC and BM at the time of SC's passing. The Preventive Services case was opened 11/6/2017, following SC's second hospitalization for a suicide attempt. TCDSS contracted with Family and Children's Service of Ithaca to provide the Dispositional Alternatives Program (DAP) to SC and BM. There were no identified service needs for the 5 yo SS that lived in the home or the 19 yo adult SS that was away at college, so they were not receiving services from TCDSS.

On 12/19/2017 around 9:30 PM, SC left the home after an argument with BM. A short time later, SC was struck by a vehicle on a road near the family's home and suffered fatal injuries. SC was pronounced deceased at the scene at 10:20 PM.

An autopsy was performed and the manner of death was determined to be suicide and the cause of death was multiple blunt trauma secondary to motor vehicle collision (pedestrian). The autopsy report stated, "evidence from the scene of death and from the autopsy is consistent with having been run over by a single vehicle and is consistent with suicide." LE investigated the incident and based on the injuries to SC and the damage to the vehicle that struck SC, it was determined SC had been laying in the road at the time he was struck.

TCDSS assessed the SS to be safe in BM's care. TCDSS provided the family with information on MH counseling and bereavement services. BM and adult SS engaged in MH counseling with their provider and BM was considering MH counseling for SS. BM informed the BF of SC about his death. TCDSS made reasonable attempts to contact BF by phone and mailed him a letter with information on bereavement services.

TCDSS verified SC's death was not considered suspicious or caused by abuse or maltreatment by BM. As no service needs were identified for the family, TCDSS closed the Preventive Services case on 3/22/2018.

PIP Requirement
TCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the TCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, TCDSS 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?** 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:
The death of SC was not reported to the SCR.

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:
TCDSS appropriately closed the Preventive Services case following the death of SC, as no additional service needs were identified for the family.

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: 12/19/2017 **Time of Death:** 10:20 PM

County where fatality incident occurred: Tompkins
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 alcohol or drugs? Unknown
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? Yes
How long before incident was the child last seen by caretaker? 45 Minutes

Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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	Male	19 Year(s)
Deceased Child's Household	Deceased Child	No Role	Male	16 Year(s)
Deceased Child's Household	Mother	No Role	Female	42 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Other Household 1	Father	No Role	Male	44 Year(s)
Other Household 2	Stepfather	No Role	Male	42 Year(s)

LDSS Response

Upon learning of SC's death on 12/20/2017, TCDSS spoke to LE to gather more information. It was learned BM contacted LE on the evening of 12/19/2017 to file a missing person's report when she could not locate SC. After the report was taken and the officer was leaving the home, sirens were heard down the street and police cars passed the home. The officer had BM follow him to the scene and it was discovered the emergency services were for SC. Officers informed BM that SC was struck by a vehicle and killed. The driver who struck SC reported to LE he never saw SC and believed he hit a deer. The driver turned around and went back to the location and realized a person was laying in the road. There were 2 witnesses interviewed by LE that had seen SC walking down the roadside prior to the incident; the first being 30 minutes prior to the incident and the second approximately 3 minutes prior. The second witness stated SC was 2-3 feet into the lane. LE informed TCDSS that SC had past suicidal ideations and attempts. An accident reconstruction was to take place and the investigation into why SC was in the road was ongoing.

TCDSS spoke to BM over the phone on 12/20/2017 and offered condolences and any services BM or SS could benefit from at that time. BM denied any additional service needs at that time and reported SS was resilient and doing ok. BM planned to utilize DAP and SC's MH counselor for support.

Several home visits were conducted and the safety of the SS was assessed. There were no concerns for the safety of the SS or the home. The MU was temporarily staying with the family for support. It was learned PS, SS's BF, moved out of the home the week prior to SC's death and BM and had been sharing custody of SS, alternating every 2 days. PS was not spoken to. SC's BF lived nearby and occasionally visited SC. BM reported she and adult sibling had informed BF of SC's death. TCDSS was unsuccessful in their attempts to contact BF by phone so they mailed him information on bereavement services. Adult SS was not spoken to as he was away at college. BM and adult sibling began MH counseling services and BM was considering counseling for SS as well. BM denied the need for any additional services.

BM reported around 9:30 PM on 12/19/2017, she and SC got into an argument and SC threw a glass and broke it. SC went outside to calm down while BM picked up the glass. BM went outside to speak to SC and she could not find him, so she filed a missing person's report. BM reported SC had 2 prior suicide attempts and hospitalizations, resulting in the referral for DAP services. SC was doing well with DAP services and there was no indication SC was having suicidal ideation. SC had been on MH medication and was regularly attending MH counseling.

LE completed their investigation and determined SC's death was caused by suicide based on SC's injuries and the damage to the vehicle. The driver did not see anyone in the road prior to striking SC and the evidence at the scene suggested SC had been lying in the road at the time.

TCDSS spoke to the DAP supervisor, SC's school staff and family members and there were no concerns expressed for BM's care of the children. The week prior to SC's death, he reported to his DAP caseworker that he was upset about the recent separation of BM and PS. He spoke about how much his parent's splitting up affected him and he didn't want SS go through the same thing he did. There was no information gathered on whether SC was under the influence of drugs or alcohol at the time of the incident. It was determined SC's death was the result of suicide and not due to abuse or maltreatment, therefore the incident did not require a hotline report being made to the State Central Register. The Preventive Services case was closed on 3/22/2018 as there were no additional service needs identified by the family.

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 reviewed by 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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
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 safety 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 death of SC was not reported to the SCR, therefore 24-hour, 7-day and 30-day safety assessments were not required. SS's safety was adequately assessed in a timely manner.				

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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
BM was provided with information on bereavement and MH counseling services for SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
BM and adult SS engaged in bereavement and MH counseling services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

Was there an open CPS case with this child at the time of death? No
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/15/2015	Deceased Child, Male, 13 Years	Mother, Female, 39 Years	Choking / Twisting / Shaking	Far-Closed	No
	Deceased Child, Male, 13 Years	Mother, Female, 39 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report was received that alleged SC resided with his BM and PS. BM became angry and out of control, yelling and screaming at SC. BM choked SC in the past and it was unknown if he sustained marks or bruises as a result. PS's role was unknown.

OCFS Review Results:
TCDSS appropriately tracked the case FAR. All household members were spoken to and engaged. The FLAG was completed accurately with the family. The family was engaged in the necessary services to address SC's MH and behavioral concerns. BM declined any additional services and the case was appropriately closed. All required persons were sent Notice of FAR and FAR closing letters.

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

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

An SCR report dated 8/12/2003 was substantiated for the allegations of XCP, IG, L/B/W against BF regarding adult sibling.

An SCR report dated 2/27/2008 was unsubstantiated for the allegations of IG and LMC against BM, PS, and BF regarding SC.

A FAR case was received 11/16/2011 with allegations of IG and L/B/W against BM regarding SC.

A FAR case was received 1/17/2012 with allegations against BM of XCP, IG, LS regarding SC, and XCP, IG regarding adult sibling.

A FAR case was received 6/12/2012 with allegations of IG against BM regarding SC.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 11/06/2017

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

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

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☒	☐	☐
If not, how many days was it overdue? The initial FASP was completed 14 days past the due date.				
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐
Additional information, if necessary: Preventive Services were provided by Family and Children's Service of Ithaca.				

Required Action(s)

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

Issue:	Timeliness of completion of FASP
Summary:	The initial FASP was due by 12/6/2017 and was not completed until 12/20/2017.
Legal Reference:	18 NYCRR428.3(f)
Action:	TCDSS will complete timely and accurate FASPs.

Preventive Services History

A voluntary Preventive Services case was open from 5/19/16-1/6/17 involving BM and SC. The case was opened due to ongoing MH concerns regarding SC, as well as SC exhibiting behavioral issues at school and home. A prevention program was recommended through the school to address these issues. Throughout the case, the family engaged in recommended services and followed through with service plan goals. By the close of the case, SC was working with providers to address his anxiety at school and around his peers, as well as his behaviors at home. All required FASPs were timely, and a Plan

Amendment was completed on 12/28/16, which noted the family had met their goals and were no longer in need of services.

A voluntary Preventive Services case was opened involving BM and SC, with a case initiation date of 11/06/2017. SC had ongoing MH concerns and continued behavioral issues at home. The family began working with DAP services and SC died on 12/19/2017. The case was opened in Connections on 12/20/2017; the initial FASP was completed on that date and all progress notes thus far were entered. A Plan Amendment was appropriately completed on 12/29/2017, which documented the death of SC. It was determined the family was not in need of services, the facts and circumstances surrounding SC's death were gathered and the case closed on 3/22/2018.

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