Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-18-002

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

Issue Date: Jun 19, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 01/17/2018
Initial Date OCFS Notified: 01/19/2018

Presenting Information

OCFS was first made aware of the death of the 16-year-old SC on 1/17/18. Erie County Department of Social Services (ECDSS) had an open CPS investigation, as well as an open Preventive Services case at the time of the SC's death. ECDSS notified the Buffalo Regional Office by phone and submitted the 7065-reporting form, and noted the SC died as a result of injuries sustained from a suicide attempt. On 1/31/18, an SCR report was made about the fatality, noting SC had a history of mental illness and 2 prior suicide attempts before her final attempt on 12/24/17. It was alleged SM was aware of these attempts and the severity of SC's MH problems, but left the SC home alone the weekend of 12/22/17-12/24/17 without a plan or alternate arrangements for her care. On 12/24/17, SC hung herself with a belt. A friend became aware and called police. SC was transported to the hospital and put on life support. On 1/17/18, life support was turned off and SC died. The cause of death was asphyxiation.

Executive Summary

On 1/17/18, OCFS was made aware of the death of the 16-year-old female SC. The fatality occurred while she was involved in both a Preventive Services case and a CPS investigation. Circumstances surrounding the fatality were later reported to the SCR on 1/31/18, prompting a separate investigation.

The SC attempted suicide on 12/24/17 by hanging herself when her mother was out of town. SC propped her phone and images of the event were seen by her friend, who reacted by calling the police. Police arrived to the SC's home and found her unresponsive. First responders were able to revive SC, and she was transported to the hospital. During hospitalization, medical professionals determined SC had limited brain activity and would have likely remained in a vegetative state the remainder of her life if kept on life support. The decision was made by the family to cease life support, and the SC died on 1/17/18. The hospital physician noted the cause of death was asphyxiation. No autopsy was performed. The ME reviewed records and certified the death.

The SC had MH diagnoses and a known history of 2 prior suicide attempts. Beginning 12/6/17, ECDSS was investigating the SM for allegedly failing to seek medical treatment for SC following her second suicide attempt in November 2017. The SCR report dated 1/31/18 alleged IG, LS, and DOA/Fatality against SM for her role in the fatal incident. ECDSS indicated the fatality investigation case against SM, as they found SM left SC home alone for an entire weekend, despite concerns surrounding SC's previous suicide attempts. Such actions and inactions indirectly contributed to the SC's death.

The SC was an only child and lived alone with SM. SC's father (BF) was involved but visited SC sparingly due to her choice and a reportedly poor relationship. Throughout the investigation, ECDSS corresponded with LE who also investigated the SC's death. No charges were filed.

ECDSS appropriately closed both CPS investigations as well as the Preventive Services case. The Preventive case thoroughly documented facts and circumstances of the death prior to closing the case, and fatality-related services were offered to the family. ECDSS also reached out the SC's boyfriend and his mother, face-to-face, and offered condolences as well as grief services.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The Investigation Determination Safety Assessment noted a Safety Decision #3 (requiring a safety plan) though there were no surviving children.

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:
The decision to close the case was appropriate.

Required Actions Related to the Fatality

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

Issue:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. When ECDSS learned the BM of SC's boyfriend inappropriately allowed her son to spend time during the day and overnight (approximately 24 hours) unsupervised by any adult at SC's home, it was not documented that this CPS concern was addressed and evaluated for the possibility of maltreatment on behalf of that BM. The evening before this was allowed, that 17yo CH consumed alcohol to the point his BM called 911 and took him to the ER, yet the immanency of the risk her poor decision-making posed to her son immediately thereafter was not recorded as having been discussed.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	ECDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/17/2018 **Time of Death:** 01:43 AM

Date of fatal incident, if different than date of death: 12/24/2017
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 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? No - but needed
At time of incident supervisor was:

- ☐ Drug Impaired
- ☒ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	Female	16 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	52 Year(s)
Other Household 1	Father	No Role	Male	49 Year(s)

LDSS Response

Two months prior to the fatal incident, ECDSS became involved with the family after a referral for Preventive Services was accepted. The SC was provided wrap-around services to address her MH, academic attendance/performance, and improve communication within the family. The Case Planner (CP) noted SC attempted suicide in November by ingesting pills and attempting to hang herself, admitting such to her therapist. CP maintained close contact with SC's therapist, who reported she informed SC's SM and BF separately about the event and advised them to seek medical attention for the ingestion of an excessive number of pills. Neither parent sought medical attention, and an SCR report was made with this concern, though allegations were only against SM. Immediately after the concern was brought to SM's attention, she

obtained a lockbox for SC's medications and suicide-related safety plans were made with the family and service providers. The plans included resource persons for SC to call if she felt suicidal (SM or SC's boyfriend), and ridding the home of objects which could be used as a noose. It was not noted that SC was not allowed to be home alone, but it was documented that the level of concern rose after the November suicide attempt and a referral to a higher level of behavioral therapy was declined by SC.

On 12/26/17, the CPS caseworker along with the Preventive Service agency became aware of the SC's hospitalization as a result of the suicide attempt on 12/24/17, and the agencies maintained close contact with one another. ECDSS began gathering information about the incident, including whether abuse or maltreatment had a role in the circumstances. ECDSS gathered information from LE, then apprised LE and the District Attorney when an SCR report was made about the fatality. It was not apparent that LE was involved in interviews with ECDSS, and there was no record of any arrests or pending charges.

During interviews, ECDSS learned SC had declined to go out of town with SM and SM's boyfriend for the weekend (beginning 12/22/17) and instead planned to stay at her boyfriend's BM's house. SM agreed to this plan, as it was not the first time she had allowed SC to stay with her 17yo boyfriend, and the boyfriend's BM was aware of the suicide concerns regarding SC. SC stayed at his house on 12/22/17, then called SM the next day stating she wanted to go home. SM returned to let SC and her boyfriend in the house, then SM left again with plans to return 12/25/17. SM knew SC would stay at her home with her boyfriend, without an adult. Additionally, ECDSS learned that into the early morning hours on 12/23/17, SC, her boyfriend, and his brother consumed alcohol to the point the SC's boyfriend passed out and his BM called 911 and took them to the ER. ECDSS discussed this incident with that BM, but did not record addressing the CPS concern that his BM then allowed her son to spend the next 24 hours at SC's house, knowing there would be no adult supervision. BF, who was in his nearby separate residence, spoke with SC by phone on 12/23/17 and learned she was home alone with her boyfriend. SC's boyfriend stated SC asked him to leave on 12/24/17, which he did. SM became aware SC's boyfriend left and SC was to spend the night at home alone. SM had left SC with 3 days' worth of her MH medication, and the rest was in the lockbox. Documentation did not note whether SC took the medication as prescribed that weekend, though there were no previously documented concerns about medication compliance. It was noted SC had symptoms of an exacerbated health condition at the time of entry to the hospital, making it unclear as to whether she had taken other necessary medication for a preexisting health condition.

SC was kept on life support, though hospital staff learned early on that she had severely limited brain activity after having suffered an anoxic brain injury. SC was unable to breathe on her own. The family made the decision to withdraw life support on 1/17/18. ECDSS offered support to the family throughout their involvement.

ECDSS made frequent collateral contacts with service providers, medical and MH providers, LE, SC's boyfriend's family, and maintained close contact with the SC's parents. SM was IND for both the fatality and open investigations. ECDSS appropriately closed all cases once all pertinent information had been gathered and documented.

Official Manner and Cause of Death

Official Manner: Suicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in Erie County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046162 - Deceased Child, Female, 16 Yrs	046163 - Mother, Female, 52 Year(s)	DOA / Fatality	Substantiated
046162 - Deceased Child, Female, 16 Yrs	046163 - Mother, Female, 52 Year(s)	Lack of Supervision	Substantiated
046162 - Deceased Child, Female, 16 Yrs	046163 - Mother, Female, 52 Year(s)	Inadequate Guardianship	Substantiated

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

Additional information, if necessary:
Services that were being provided while the SC was alive were ended upon the SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Support services were offered to the family related to the fatality, but it is not documented that any services were utilized while the case was open.

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? 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? N/A
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)
12/06/2017	Deceased Child, Female, 16 Years	Mother, Female, 52 Years	Lack of Medical Care	Indicated	No
	Deceased Child, Female, 16 Years	Mother, Female, 52 Years	Inadequate Guardianship	Indicated	

Report Summary:
SCR report alleged the SC, age 16, had a history of suicide attempts. The SM was aware of this and failed to secure an over-the-counter medication. Three weeks before the SCR report, the SC tried to hang herself and took 2 handfuls of the over-the-counter medication. It was recommended the SC see a doctor after ingesting the pills, but the SM failed to bring her.

Determination: Indicated **Date of Determination:** 03/12/2018

Basis for Determination:
ECDSS investigated and determined that upon learning of SC ingesting the pills, SM did not call Poison Control or seek medical attention until 3 weeks later. SC's medical provider confirmed some sort of medical attention should have been sought, or Poison Control should have been called. During the investigation, beginning 12/22/2017, SM left SC home alone the entire weekend with no plan or alternate arrangements for SC's care. On 12/24/2017, SC hung herself. SC died on a later date as a result of the incident. ECDSS determined SM's inactions contributed to the negative impact SC sustained.

OCFS Review Results:
ECDSS completed a thorough investigation into the allegations against SM. ECDSS met frequently with the family and offered services surrounding the fatality. ECDSS began a separate CPS investigation into the death when it was determined such investigation was warranted.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
02/08/2017	Deceased Child, Female, 15 Years	Mother, Female, 51 Years	Inadequate Guardianship	Unfounded	Yes

Report Summary:
SCR report alleged the SC, age 15, had MH diagnoses. For the past 4 years, on and off, she was engaging in self-harming behaviors. Within the previous year, SC had attempted suicide on at least 2 occasions. In July 2016, SC overused a prescription medication; again on 2/6/17, SC took 45 pills of a different prescription medication. The SM had been encouraged to utilize a safety plan limiting SC's access to medications and sharp implements in the home, but she failed to do so. The role of the BF was unknown.

Determination: Unfounded **Date of Determination:** 03/27/2017

Basis for Determination:
ECDSS investigated and determined SM ensured SC's medications were locked up and SC did not have access. SM's actions occurred immediately following the suicide attempt. SC was noted as actively compliant with her MH treatment. Preventive services were offered, but the family declined.

OCFS Review Results:
ECDSS interviewed each family member and learned that despite a previous suicide attempt, SC had shown improvement and was participating in her MH regimen and SM had not had reason to lock up medications. ECDSS diligently documented conversations with the family and observations of medications being locked up. ECDSS appropriately offered services. Concerns that became known regarding SC failing all classes due to failure to attend instruction should have been addressed further and may have required investigation and/or services.

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

Issue:
Determination of Nature, Extent and Cause of Conditions (Report)

Summary:
In addition to conditions enumerated in a report, CPS is required to determine any other condition that may constitute abuse or maltreatment. When the school notified ECDSS that SC was failing all classes due to poor attendance, the issue was not addressed with SM or SC.

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

Action:
ECDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

[redacted]

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

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

Known CPS History Outside of NYS

There is no known CPS history for the family 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: 10/10/2017

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

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
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?	☒	☐	☐	☐
If yes, was the response appropriate to the circumstances?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
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: Child & Adolescent Treatment Services Wrap Program; Best Self Behavioral Health.				

Preventive Services History

The SC was involved in an open Preventive Services case, initiated 10/10/17 as a referral for wrap-around services to address the SC's various issues. SC was displaying some oppositional behavior with underlying anxiety, and it was identified SM could use in-home support to assist with family communication and setting limits. SC also exhibited runaway behaviors, increasing substance use, and had missed a considerable number of school days due to reported MH issues. SC was evaluated for MH and received counseling services. She also attended home instruction due to anxiety at

school. An In-Home Worker was assigned to help with skill-building. In a FASP dated 12/20/2017, it was noted SC's therapist referred SC back to dialectical behavioral therapy (a higher level of care) due to recent unsafe behaviors, though SC refused. Therapist planned to discharge SC as she was following treatment recommendations at that time and offer another therapist, though SC refused that as well. The family planned to continue with the In-Home Worker and wrap services. The family's strengths, concerns, and progress were documented in detail. The Case Planner spoke with all necessary parties upon learning of the fatal incident, which occurred while the case was open, and gathered and documented facts and circumstances about the event. The case closed shortly thereafter, on 2/23/18.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

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 ECDSS must unfortunately concur with the compliance issues noted by the reviewer – one with respect to the fatality investigation and one with respect to an investigation conducted within the three years preceding the fatality. With respect to the fatality investigation, we agree that, when we learned that the mother of the subject child's boyfriend allowed her son to spend unsupervised time at the subject child's home on the day after her son had been taken to the hospital for excessive alcohol consumption, we should have documented an evaluation of possible maltreatment on behalf of the boyfriend's mother. With respect to the investigation of the SCR report dated February 8, 2017, we find that the child did have a history of poor school attendance, contributing to failure in all her classes, and we concur that this issue was not discussed with the mother or child. This issue was identified during a collateral telephone call to the school guidance counselor, and while the guidance counselor also reported that the child had just begun home instruction earlier in the week, we do agree that concerns regarding the child's educational progress should have been explicitly addressed with the family. The following corrective actions were implemented in response to the above citations:

- An agenda item was added to the Child Protective Services (CPS) Team Leader meeting held on June 12, 2018 to remind supervisors of the statutory requirement that CPS is required to determine any other condition arising during an investigation that may constitute abuse or maltreatment and that, when identified, those new concerns must be addressed with all applicable caregivers in an effort to determine whether the action(s) or inaction(s) constitute abuse or maltreatment.
- The CPS supervisors were instructed to carry this message back to their respective caseworkers, and this reminder will be included in the minutes of the Team Leader meeting which are circulated to staff.

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