Child Fatality Report Release of Information to the Public

Person ID: 104242596

County of Child's Residence: BRAZOS

Gender: Male

Age: 17 Year(s) 8 Month(s)

Date of Death: 12/13/2022

On the date of the fatality, the child was not in DFPS conservatorship and was living with the child's parent, a managing conservator, a legal guardian or other person entititled to the child's possession.

Child's Name: Borak,Dennis

Current Report(s) of Abuse/Neglect:

Intake Date(s): 12/14/2022

Summary of Allegation(s)/Investigation:

The Department received a report of a fatal event on December 14, 2022. The initial report stated that the deceased child had mental health issues over the past two years and had been involved in a sexual assault case as a suspect. The deceased child had dropped out of school due to the case. The report stated that on the night of December 12, 2022, around 5:30pm, the deceased child and his parents were in an argument about the deceased child wanting to have a friend over and the parents did not agree. The argument continued about the deceased child's poor life choices and the mother brought up a prior suicide attempt by the deceased child. The deceased child then ran inside the house, grabbed a pistol off his father's safe in the master bedroom, and ran of the house. By the time the parents got inside the home, they heard a gunshot in the distance. About 25 minutes later, the parents found the deceased child in the back of the house in a field. The deceased child had shot himself in the head. The mother reported to law enforcement that the deceased child's previous suicide attempt was her fault because she had told him that if there was any truth to the sexual assault, then he should kill himself. Law enforcement noted that the mother appeared to under the influence and she was extremely belligerent. The report stated that the weekend prior, the family was at a football game in San Antonio and while the deceased child was at the hotel by himself, he sent a picture text message to his girlfriend of a gun in his lap and he stated that he was not doing so well. The girlfriend contacted the parents and when they arrived back to the hotel, everything appeared fine.

The Department's investigation determined that the father admitted to leaving the gun on top of the safe. Both parents reported arguing with the deceased child because he wanted to have a friend over and they would not agree. The deceased child was upset, was able to access the gun, and then shot himself. The parents did not allow the deceased child's siblings to be interviewed.

The medical examiner completed an autopsy. The final results were not available when the Department's investigation closed. The law enforcement investigation was still ongoing when the Department closed its investigation.

Investigation Findings:

The Department confirmed allegations that the deceased child's mother and father committed Neglectful Supervision of the deceased child, which led to the child's death. The parents were aware of the deceased child's mental health issues, prior suicide attempt, and recent picture the deceased child had taken holding a weapon. The parents did not take precautions to ensure the deceased child did not have access to the weapon again.

Safety Assessments:
12/28/2022: Safety Assessment - Initial: Safe

Risk assessment final risk level: high

Safety and Risk Assessment Factors Identified:

Case Action:

Fam refusal/No legal interven poss-Close

Services and Referrals Provided to the Family:

Counseling and Evaluation

Other Services:

The family was provided community resources for grief counseling.

Other Actions Taken to Mitigate Risk:

If one or more children were previously removed from the home, for each conservatorship episode, summarize dates of conservatorship and type of placement at the end of conservatorship:

Previous Report of Abuse/Neglect:

Intake Date(s): 5/6/2021, 5/7/2021

Summary of Previous Allegation(s)/Investigation:

The Department received a report that the deceased child had been taken to the hospital for an intentional ingestion of Tylenol and Ibuprofen. The deceased child needed bloodwork completed before he could be admitted into a mental health facility, but the deceased child's father left before the deceased child could be seen. The father was contacted after he left and advised of the seriousness of a Tylenol ingestion. The father advised he would take the deceased child to see someone the following day. The father was asked to take the deceased child to the emergency room and he agreed, but the he called back and said the deceased child had taken the car, wrecked it, and ran away before he could be taken to the emergency room. A second report was received on May 7, 2021. The report stated that while on the way to the emergency room, the deceased child was punched and choked by his father in the car. The deceased child jumped out of the car and was observed to have a swollen left eye and cuts on his knuckles.

During the Department's investigation, the deceased child was interviewed and initially said that he felt unsafe, his father punched him, and that he tried to commit suicide due to seeing his girlfriend on snapchat with another guy. During the interview, the deceased child began to cry and said he was not truthful about taking medication or that his father had hit him and he didn't know why he lied. The deceased child was referred to an inpatient facility for mental health treatment.

Investigation Findings:

The Department did not confirm the allegations that the father committed physical abuse or medical neglect of the deceased child. The deceased child reported that he was not truthful regarding the overdose or the assault by his father. The parents were in agreement with mental health services for the deceased child.

Safety Assessment:
5/6/2021: Safety Assessment - Initial: Safe
6/25/2021: Safety Assessment - Case Closure: Safe

Risk assessment final risk level: N/A abbreviated investigation

Safety and Risk Assessment Factors Identified:

Case Action:

Close - Abbreviated INV

Services and Referrals Provided to the Family:

Counseling and Evaluation

Other Services:

The family was provided a list of therapists and counselors in their community.

Other Actions Taken to Mitigate Risk:

Previous Report of Abuse/Neglect:

Intake Date(s): 9/3/2021

Summary of Previous Allegation(s)/Investigation:

The Department received a report on September 3, 2021 stating that the deceased child had been placed in juvenile detention the night prior for assault family violence. The deceased child report that his father threw him into a fridge and a dog kennel during the incident. The report stated that the deceased child had self-harming injuries and was put on medication by his counselor in May 2021.

The Department's investigation found that the parents were taking the deceased child to see a pediatric psychologist to get him on a mood stabilizing medication. The deceased child was interviewed and reported no abuse and laughed off the fact that he and his father got into a physical altercation. The deceased child's siblings were also interviewed and reported no abuse or neglect occurring in their home. The father reported that he defended himself when attacked by the deceased child.

Investigation Findings:

The Department did not confirm the allegation of physical abuse of the deceased child by his father. The deceased child reported no physical abuse. The father said that he was defending himself after he was attacked by the deceased child when attempting to take away a lighter.

Safety Assessments:
9/8/2021: Safety Assessment - Initial: Safe

Risk assessment final risk level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

The deceased child was receiving mental health services in the community.

Other Actions Taken to Mitigate Risk:

Other Previous Report of Abuse/Neglect:

Intake Date(s):

Summary of Previous Allegation(s)/Investigation:

Investigation Findings:

Safety and Risk Assessment Factors Identified:

Case Action:

Services and Referrals Provided to the Family:

Other Services:

Other Actions Taken to Mitigate Risk:

Note: This report was prepared on 10/20/2023 and does not include corrections or updates, if any, that may be subsequently made to DFPS data on or after the date this report was prepared.