Child Fatality Report

Report Identification Number: RO-17-026

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

Issue Date: Jan 16, 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: 14 year(s)
Jurisdiction: Ontario
Gender: Female
Date of Death: 07/14/2017
Initial Date OCFS Notified: 07/17/2017

Presenting Information

SM was aware the female SC (14yo) had a history of serious mental health issues; including depression that required multiple hospitalizations. SC required a higher level of supervision by SM as a result of her mental health history. On 7/14/17, SC died by suicide at SM's home by hanging herself in the residence. SM was home at the time of the incident. SM failed to adequately supervise SC. SC made posts on her Facebook page on 7/14/17 saying she wanted to hurt herself. The roles of BF and MGF were unknown.

Executive Summary

Livingston County DSS (LCDSS) was investigating an SCR report they received on 5/3/17 involving the 14yo SC. Ontario County Department of Social Services (OCDSS) was assigned secondary as SC went to live with SM. During the investigation, on 7/17/17, it was learned SC had completed a suicide on 7/14/17. LCDSS notified the Regional Office and completed the 7065 form as soon as they learned of SC's death. On 7/19/17, a subsequent SCR report was received alleging DOA/Fatality, LS & IG against SM of the SC. LCDSS began their investigation and coordinated efforts with LE. Since the death was on 7/14/17, LE had already completed their interviews with the family and declined to accompany CW during their interviews. CW obtained records from LE such as statements, photographs, copies of text messages, and social media posts.

The investigation revealed that on 7/14/17, SM saw SC in the kitchen on her cell phone around 1AM and then SM went to bed. SM's boyfriend (OA), and OA's 9yo daughter (OC) were also in the home sleeping at the time. Around 2AM, SC made a post on social media that said "sorry." Shortly after, on another social media account, SC wrote "I'll be watching over you." At 11:30AM, SM was awoken by her dog barking. When SM got up to bring the dog out, she saw SC's body hanging in the living room. SM screamed and called 911. 911 instructed SM to cut her down and then go outside when police arrived. MGF lived in the home and arrived home around 7:15AM and did not see anything, as SC's body was in an area of the house that was not clearly visible, and not often used. SC had 2 SS, ages 10 & 15, who lived with BF, and were at his home at the time. OA brought OC to her mother's home around 6:30AM. OC reported when she left the home, she saw SC but could not tell she was hanging or that she was dead, so she never said anything to anyone.

CW was unsuccessful in contacting SM or BF on 7/17/17, but verified with a school source who saw the CHN on this day that they appeared safe and were surrounded by family members at BF's home. CW made an unannounced home visit to BF's residence on 7/18/17 and assessed the safety of the SS. BF and SS were appropriately upset with the death of SC. BF and SS had several family members visiting the home to provide extra support. CW offered the family supportive services and BF said they would consider counseling or other supports in the future. School social worker (SSW) visited the home on 7/17/17 and offered resources as well. SS expressed no thoughts of wanting to hurt themselves but did express interest in counseling.

OCDSS completed all safety assessments and fatality reports adequately and on time. CWs interviewed all subjects and obtained pertinent information from several collaterals. CW provided the family with several resources for bereavement counseling, supportive services, and materials on grieving. The final autopsy was not complete at the time of case closing as the ME was waiting on SC's toxicology report which would take several months. SC's death was ruled a suicide by hanging.

The allegations of DOA/Fatality, LS, & IG against SM for SC were substantiated and the case was indicated and closed

on 8/30/17. SC had an extensive history of MH issues, previous suicide attempts, cutting behaviors, and self-harm. The night of 7/13/17, SC communicated with SM that she was having suicidal thoughts. SM failed to provide SC with adequate supervision or an alternate plan of care. LE did not file any criminal charges in this case. SS1, SS2, and OC were all involved in counseling at the time of case closing. The SS were not visiting SM's home but continued to visit with SM outside of her home. SM planned on moving.

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

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 activity 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: 07/14/2017 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Ontario
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:

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	14 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	63 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	33 Year(s)
Other Household 1	Father	No Role	Male	34 Year(s)
Other Household 2	Other Child - Mother's Partner's Child	No Role	Female	9 Year(s)

LDSS Response

CW contacted LE and unsuccessfully attempted to contact the family on 7/17/17. A school-based preventive worker (SCW) visited the family and saw the BF and surviving siblings, as well as the PGM who had come to stay to provide support to the family. SS appeared safe.

On 7/18/17, CW made an unannounced visit to the BF's home. Present were BF, his GF, the two SS and several extended family members. It was learned that on the evening of 7/13/17, SC had been texting BF and GF that she was sad. BF offered to take her to his home, but BM declined, as SC had appointments the next day. SC had been prescribed antidepressants. It is unknown if she was taking them regularly while at SM's home. CW interviewed both SS; CW provided the family with information on bereavement and counseling.

The 7/19/17 fatality report made to the SCR added OCDSS as a secondary jurisdiction because SM"s residence was there. OCDSS notified the DA and worked with local LE. Calling hours were on this night and after supervisory consult it was decided a home visit would not be completed at this sensitive time. The family reported had multiple supports for the SS, including a counselor. SS would not be visiting SM's home; SM has been visiting with the SS at BF's home, or taking them elsewhere.

On 7/21/17, CW made a home visit to SM's house. SM said the week leading up to SC's death, SC had been using over the counter medications to become impaired and stole alcohol from relatives. SM took SC to MH appointments and probation on 7/13/17. The probation officer gave SC a suicide assessment at this appointment and SC answered no to all the questions. Between 3-6PM on that night, SC texted SM and said she was having suicidal thoughts. SM said she was probably having those thoughts due to coming off the over the counter medication she had been taking. When SM arrived home from work around midnight on 7/14/17 SC was on the phone with her boyfriend, happy and joking around. SM went to bed around 1AM and saw SC still in the kitchen using her phone. When SM woke up at 11:30AM, she found SC hanging on the stairs in the living room. SM called 911 and took SC down. The night of 7/13/17, OA and OC were also at home. OA was responsible for the supervision of SC while SM was working, although SM said they do not communicate due to past issues. OA was in his bedroom most of the night and told CW he "never goes upstairs to SC's room." CW then spoke with MGF who drives a truck to New Jersey every night and returned to the home on 7/14/17 around 7:15AM. MGF reported he did not see anything that occurred. MGF never had much interaction with SC and reported she mostly stayed in her room with the door shut. SC hung herself in a corner of the home that was not visible and often not used.

Later that day, CW interviewed OC at her home. Around 6:30AM, her father woke her and asked her to go start his car and wait for him to bring her home. This is when OC first saw SC. OC did not realize SC was dead. OC said she felt like something was wrong but never said anything to her father. CW addressed setting up counseling for OC. OCM said she already contacted an agency to start OC with counseling and she is familiar with the services available at OC's school. CW offered a referral for preventive services.

During the course of the investigation, CW spoke to EMS, probation, an MH counselor, and reviewed records from the four MH facilities SC had involvement with. On 6/1/17, SC told one of her MH counselors of her suicide plan (the same plan she used in her suicide completion), and as a result, SC was admitted to an MH facility for almost 3 weeks.

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?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
042884 - Deceased Child, Female, 14 Year(s)	042885 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
042884 - Deceased Child, Female, 14 Year(s)	042885 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
042884 - Deceased Child, Female, 14 Year(s)	042885 - Mother, Female, 33 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐
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?	☐	☐	☒	☐

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	☐	☐	☐	☐	☐	☒	☐

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? 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)
05/03/2017	Deceased Child, Female, 14 Years	Father, Male, 33 Years	Lacerations / Bruises / Welts	Unfounded	Yes
	Deceased Child, Female, 14 Years	Father, Male, 33 Years	Inadequate Guardianship	Unfounded	

Report Summary:
BF has beaten SC in the past when she had done something wrong. As a result of the beating, SC sustained bruises. It was unknown if BF had used an instrument or his hand and it is unknown where on the body SC sustained bruises. On 5/2/17, SC broke curfew. On 5/3/17, SC got into a fight in school and was suspended. SC was afraid to go home for fear her father would beat her.

Determination: Unfounded | **Date of Determination:** 08/02/2017

Basis for Determination:
CW interviewed SC about BF hitting her and she said he slapped her in the face "a long time ago." SC said her face was red at the time. All other members of the family deny there is any kind of physical abuse in the home. SS1 and SS2 both said they'd never been hit by anyone.

OCFS Review Results:
CW provided parents with a lot of different resources to help the family. CW interviewed everyone named on the report and all deny any use of physical discipline or abuse. Father holds SC accountable to rules, and when she breaks the rules, she accuses father of some kind of abuse. SC then goes to live with her mother who is not as strict. CW made several home visits, discussed safe sleep (as there was a 1yo living in the home), reviewed CPS history, and contacted several collaterals such as SC's therapist, a school based preventive caseworker and SC's probation officer who stated SC had a history of not being very credible.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
Even though SC was assessed as safe on 5/4/17, the 7-day safety assessment was not completed until 5/18/17, making it 8 days late.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
Within seven days of receipt of the report, a preliminary assessment of safety must be conducted to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm. The results of each safety assessment must be documented in the case record in the form and manner required by OCFS.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
06/07/2016	Deceased Child, Female, 13 Years	Father, Male, 33 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Female, 13 Years	Father, Male, 33 Years	Sexual Abuse	Unfounded	

Report Summary:
BF had a history of sexually abusing SC (14 at the time). On an unknown date in 2015, BF had sexual intercourse with SC. BF would take off SC's clothes and cover her eyes. In the car, BF attempted to put his hand down SC's pants. The roles of SM, and the two siblings were unknown.

Determination: Unfounded **Date of Determination:** 05/11/2017

Basis for Determination:
SC had two MH hospitalizations. SC was very jealous of her father's girlfriend who was very young. SC was out on a weekend pass from a MH hospitalization and her father caught her with an older boy who she had met on the internet. SS1 and SS2 denied their father had ever abused them or SC. BF caught SC on the internet messaging an older boy about meeting up for sex. When BF told SC he saw her message to the older boy, SC made a threat to her BF saying she had "stuff on him." SS1 told CW SC was lying, and SS1 was very upset by this stating SC lies and doesn't follow the rules.

OCFS Review Results:
Upon receipt of the report, OCDSS confirmed with source that the information in the report was accurate. CW then contacted LE to coordinate a joint investigation. CW contacted multiple collaterals such as school officials, LE, and had the child forensically interviewed at a CAC. LE and CW interviewed BF, SM, both SS, and no one disclosed any abuse. Both parents acted appropriately in getting SC mental health help she needed. SC was put on probation. CW learned SC had a history of lying when she got in trouble.

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

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
There were several progress notes that were entered a very long time after the event date. Several notes were entered up to a year after receipt of information.

Legal Reference:
18 NYCRR 428.5

Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

[redacted]

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

FAR 5/20/13-SC was on visitation at SM's home. SC was left unsupervised and tried cutting a piece of wood with an axe, missed, and hit her foot. SC sustained a severe cut to her foot requiring stitches. CW followed all FAR regulations to work with the family.

Known CPS History Outside of NYS

There is no known CPS history outside of NYS.

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

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