



Report Identification Number: NY-17-142

Prepared by: New York City Regional Office

Issue Date: May 22, 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: 15 year(s)

Jurisdiction: New York
Gender: Female

Date of Death: 12/15/2017
Initial Date OCFS Notified: 12/16/2017

Presenting Information

The fifteen-year-old SC was diagnosed with a mental illness that requires her to take medication. Approximately one month ago she stopped taking her medication and was cutting her wrist. On 12/15/17, at 12:00 AM, the SC and her parents engaged in an argument regarding an unknown situation. At that time, the SC threatened to commit suicide. The parents failed to seek appropriate medical attention or check on the SC throughout the night, knowing that she wanted to commit suicide. At 9:45 AM, the SM checked the SC and found her unresponsive. She was found with a plastic bag over her head and a belt around her neck. The SC was pronounced dead at 10:00 AM on 12/15/17.

Executive Summary

On 12/16/17, the SCR registered a report regarding the death of a fifteen-year-old female who was found in her bed unresponsive. The SM found the SC with a plastic bag over her head and a belt around her neck at 9:40 AM on 12/15/17. The allegations of the report were DOA/Fatality, LS and LMC of the SC by the parents. The ME reported to have found nothing suspicious regarding the cause of death and that it appeared to be a suicide. There were no minor children at the home; however there is an adult sibling that was out of state at the time of the incident.

ACS initiated the investigation within the mandated time frame and contacted appropriate collaterals such as LE, EMS, the parents and the adult sibling. ACS learned from LE that the parents and the SC had an argument because she had been diagnosed with a clinical condition and refused to take her medication for the past month. A few days prior to the discovery, the SC had expressed to her parents that she wanted to kill herself. The SM contemplated taking the SC to the hospital; however, after expressing her concerns to the SC's therapist who recommended they give the SC "space, she will be okay," she opted out. On the night of 12/14/17 was the last time the parents saw the SC alive. LE reported the SF left the home on 12/15/17 at 8:00 AM for a business trip and did not check on the SC. ACS learned that on 12/15/17, At 9:45 AM, the SM checked on the SC and found her unresponsive, with a plastic bag over her head and a belt around her neck.

ACS learned that on 12/15/17, EMS responded to a 911 call for medical assistance at 9:50 AM at the case address. The SC was pronounced dead at 10:00 AM. According to EMS, LE had already responded and as they assessed the SC, they found she had no pulse and rigor mortis was evident. The ME transported the SC to the hospital and on 12/19/17, reported they found no outward signs of neglect or abuse. The ADA reported no criminality was found and that the final report was pending.

ACS made several attempts between 12/19/17 and 1/12/18 to interview the family; however, the parents refused to be interviewed. The family's attorney requested that all communication be made directly to his office. According to ACS' documentation, the attorney informed ACS to put together a list of questions for the parents and the attorney would have them respond and give the information to ACS. ACS has not yet determined this investigation and there were no further documented attempts to obtain information through the parent's attorney by ACS' Family Court Law Services. ACS has not furnished a list of questions for the parent's attorney as requested.

As of 5/22/18, ACS has not yet made a determination on this report.

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? Unable to Determine

Determination:

- Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation? The CPS report had not yet been determined at the time this Fatality report was issued.
- Was the determination made by the district to unfound or indicate appropriate? Unable to Determine

Explain:

ACS has not yet determined this investigation and there were no further documented attempts to obtain information through the parent's attorney by ACS' Family Court Law Services.

- Was the decision to close the case appropriate? Unknown
- Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Unable to Determine
- Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:

ACS has not yet made a determination.

Required Actions Related to the Fatality

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

Issue:	Overall Completeness and Adequacy of Investigation
Summary:	ACS did not make a diligent effort to assess whether the parents were negligent of Lack of Supervision and Lack of Medical Care. ACS did not furnished a list of questions for the parent's attorney as requested.
Legal Reference:	SSL 424.6; 18 NYCRR 432.2(b)(3) and 18 NYCRR 432.2 (b)(3)(iii)(c)
Action:	ACS must submit a corrective action plan within 45 days that identifies what action it has taken or will take to address the issues cited in this report. ACS staff must meet with staff involved with this fatality investigation and NYCRO of the date of the meeting, who attended, and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/15/2017

Time of Death: 10:00 AM

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FINAL



Time of fatal incident, if different than time of death: 09:45 AM

County where fatality incident occurred: New York

Was 911 or local emergency number called? Yes

Time of Call: 09:45 AM

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? No

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? 9 Hours

Is the caretaker listed in the Household Composition? Yes - Caregiver 1

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	Adult Sibling	No Role	Male	19 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	15 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	59 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	55 Year(s)

LDSS Response

On 12/16/17, the SCR registered a report regarding the death of a fifteen-year-old female SC who was found unresponsive in her bed by the SM at 9:40 AM.

On the same date, ACS initiated the investigation by contacting LE and the ME who confirmed the date and time of death. ACS also obtained information from EMS, ADA, and LE. ACS learned the SC was diagnosed with a clinical condition and was prescribed medication; however, she had been taking the medication sporadically for the last month. ACS also learned the SC told her parents she wanted to commit suicide. The allegations of the report were DOA/Fatality, LS and LMC.



ACS learned from LE there were no surviving siblings or other children in the home. The adult sibling was out of state at the time of the discovery. The SF had left the home at 8:00 AM that morning for a business trip and did not check the SC. ACS documented the SM found the SC laying on her bed, face up, with a plastic bag over her head and a belt tied around her neck. The SM summoned 911 and went to her neighbor's apartment as she was alone and could not bear to be in the home. LE were the first responders, and their investigation determined there was no criminality.

On 12/16/17, ACS contacted EMS who reported they arrived at the case address at 9:50 AM and observed the SC with no pulse and beside her were her cell phone and headphones. EMS reported that the SM explained that the SC was grappling with the fact that she was adopted. Also, she was having issues at school and was not attending. EMS added that the SC had a clinical condition and on the night prior to the incident, the parents and SC argued about her refusal to take her medication.

On the same date, ACS visited the case address and began to interview the SM who confirmed the reported information. The SM added that she and the SF had argued with the SC about going to her boyfriend's house where there was no adult supervision. The parents would not allow the SC to go and the SC was upset. During the interview with the SM the SF awoke and demanded ACS leave their home. Later that day, ACS returned to the case address and met with the parents who cried hysterically as the Specialist consoled the SF. The SF declined to give ACS consent to speak with the SC's physician or clinical health therapist and postponed the interview.

On 12/18/17, ACS contacted a neighbor of the family who stated only that it was a sad situation with no explanation. On the same date, ACS visited the case address and attempted to complete an interview with the parents; however, a family friend told ACS the parents declined to be interviewed.

On 12/19/17, the family's attorney contacted the Specialist to formally decline to allow ACS an interview with the parents and requested that ACS direct all further attempts to speak or communicate with the family be directed to his office.

ACS completed a search on the Attendance Tracking System for the SC and it reflected she was transferred from one school to another which she attended until 12/14/17. ACS found no criminality or DIR records by the parents. On 1/12, 1/30/17 and 2/13/18, ACS contacted the office of the ME and the final report remained pending.

As of 5/22/18, ACS has not yet determined this investigation and there were no further documented attempts to obtain information through the parent's attorney by ACS' Family Court Legal Services.

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)?No

Comments: The ACS investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

Comments: There is no OCFS approved Child Fatality Review Team in the New York City region.

SCR Fatality Report Summary



Child Fatality Report

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045394 - Deceased Child, Female, 15 Yrs	045395 - Mother, Female, 55 Year(s)	Lack of Medical Care	Pending
045394 - Deceased Child, Female, 15 Yrs	045396 - Father, Male, 59 Year(s)	DOA / Fatality	Pending
045394 - Deceased Child, Female, 15 Yrs	045395 - Mother, Female, 55 Year(s)	DOA / Fatality	Pending
045394 - Deceased Child, Female, 15 Yrs	045396 - Father, Male, 59 Year(s)	Inadequate Guardianship	Pending
045394 - Deceased Child, Female, 15 Yrs	045396 - Father, Male, 59 Year(s)	Lack of Medical Care	Pending
045394 - Deceased Child, Female, 15 Yrs	045395 - Mother, Female, 55 Year(s)	Inadequate Guardianship	Pending

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case Planners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Agency Personnel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Daycare Provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the investigation adhere to established protocols for a joint investigation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional information:

The adult sibling was not at home at the time of the incident and the family declined to be interviewed.

Fatality Safety Assessment Activities



	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:

The parents declined to be interviewed and obtained legal counsel to prevent ACS from contacting them directly. The parents requested that all communication be sent to their attorney.

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:

The parents requested that all contact be made through their attorney.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No

Explain:

On legal advice, the family declined to be interviewed.

History Prior to the Fatality

Child Information

- Did the child have a history of alleged child abuse/maltreatment? No
- 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

There is no CPS investigative history in NYS within three years prior to the fatality.

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 outside of NYS.

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