Child Fatality Report

Report Identification Number: SV-18-041

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

Issue Date: Dec 10, 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: Westchester
Gender: Female
Date of Death: 06/18/2018
Initial Date OCFS Notified: 06/25/2018

Presenting Information

The 7065 Reporting Form was submitted to OCFS by WCDSS on 06/19/18 after WCDSS made a home visit and was told by a family member that the 16YO SC had committed suicide by hanging.

Executive Summary

WCDSS became involved with the family due to an SCR report dated 4/30/18 that alleged 5 years prior the SF kicked the SC down the stairs when she refused to attend a planned activity. The report further alleged concerns regarding the SF's inappropriate sexual behaviors in the presence of the SC. The report was under investigation at the time of death. A 7065 Report Form was completed and sent to OCFS on 06/22/18, the same date WCDSS was notified of the fatality.

The 16-year-old SC resided with her mother (BM) at the time of her death. SC had recently been released from a psychiatric hospital. Although BM gave LDSS contact information for the hospital social worker, the record did not contain a release form that would have allowed CPS to obtain treatment recommendations upon her release

LE records reflected LE arrived to the mother's home at 9:08PM and found the SC deceased in her closet from an apparent suicide. LE interviewed the SF regarding the SC's death. SF reported he spoke with the SC at 6:38PM and there was no indication that anything was wrong. SF further reported to LE that the SC had recently been released from an inpatient mental health facility and was scheduled to enter a 10-week inpatient program to help manage her MH diagnosis.

Although the LE records reported the death as a suicide, WCDSS did not follow up with relevant collateral contacts or the mother regarding the death of the SC. There were no further details surrounding the SC's death, or the events preceding it. On 6/29/18, WCDSS unfounded and closed the investigation of the 4/30/18 report.

Although a safety assessment was completed within the required timeframe, it did not reflect how it was determined there were no SS or other children in the household. The record did not reflect how it was determined there was no cause to suspect the death was a result of abuse or maltreatment by the caretaker.

PIP Requirement
WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going 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 fatality was not SCR reported and therefore there were no allegations surrounding SC's death.

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:
The record did not show how it was determined there was no reasonable cause to suspect maltreatment caused the death, or assessment of the family's service needs after.

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: 06/18/2018 **Time of Death:** 09:17 PM

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

County where fatality incident occurred:	Westchester
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 - Not needed given developmental age or circumstances

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	No Role	Female	16 Year(s)
Deceased Child's Household	Mother	No Role	Female	61 Year(s)
Other Household 1	Father	No Role	Male	68 Year(s)

LDSS Response

At the time of SC's death, there was an ongoing CPS investigation which began on 04/30/18. The SCR report dated 4/30/18 alleged concerns SF kicked SC down the stairs when she was 11 years old because she refused to attend an activity. Additional concerns included the SF engaging in sexual activity in the presence of the child.

WCDSS did not see or interview the SC in the 2 months the investigation was open. WCDSS assessed the safety of the child within 24 hours and learned by phone that she was being hospitalized for suicidal ideations. Efforts were made by WCDSS to visit the child within the first 24 hours. WCDSS contacted the admitting hospital who reported the child was stable to be interviewed, however the BM prevented WCDSS access to the child. On 6/29/18, after the child's death, WCDSS unsubstantiated the allegations in the 4/30/18 report, although required familial and collateral contacts had not been made.

WCDSS received LE records on 6/28/18. The LE records reflected the SM and the SC were at home together when SC went upstairs to her room. SM reported to LE she last spoke with the SC at approximately 8:15PM. SM went upstairs to bed at 8:45PM and observed the SC's bedroom door to be closed. SM knocked with no response and could not access the room. SM found something to unlock the door and upon entering the room, SM found the SC hanging in the closet from a knotted rope and called 911.

In response to the fatality, WCDSS did not make an SCR report stating in their investigation conclusion the fatality was not due to abuse or neglect based on the absence of an SCR report from the MH providers. However there were no documented attempts to speak with hospital staff, SC's pediatrician, the MH hospital where the SC was last admitted, BM, or other collateral sources surrounding SC's death. WCDSS offered grief counseling to the SF who refused services, but did not offer any services to the BM. The family was not assessed for other service needs.

Between the initial report on 4/30/18 and the child's death on 6/18/18,WCDSS did not make contact with or interview the SC. WCDSS did not document whether there were any SS or other children in the SC's home. WCDSS unsubstantiated the allegations in the SCR report, and closed their investigation on 06/29/18. In their determination, WCDSS concluded since there were no concerns within the past three years requiring CPS intervention thus they had no basis of suspicion to register a DOA/fatality report or substantiate the allegations in the open investigation.

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? Yes

Comments: The fatality was reviewed by the OCFS approved Child Fatality Review Team in Westchester County on 07/06/18.

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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
School	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Medical Examiner / Coroner	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
There was no SCR report about the fatality.

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:
WCDSS offered SF bereavement services, but did not offer services to the BM in response to SC's passing.

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? Unable to Determine
Explain:
It was not documented whether or not there were surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Bereavement services were not offered to BM following the fatality.

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?	Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/30/2018	Deceased Child, Female, 16 Years	Father, Male, 68 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report was received on 04/30/18 alleging that approximately 5 years ago, the SF kicked the SC down the stairs because she refused to attend a planned activity. It was not known if the child sustained visible injuries. The SF also engaged in inappropriate sexual behavior in the child's presence in the past and this happened on a regular basis.

Report Determination: Unfounded | **Date of Determination:** 06/29/2018

Basis for Determination:
WCDSS should have spoken with the hospital social worker and/or the parents to determine if there were treatment recommendations as a result of the SC's hospitalization and what level of supervision was deemed necessary due to the SC's suicidal ideations. Due to inadequate documentation in the case record, it cannot be determined whether the UNF determination was appropriate.

OCFS Review Results:
WCDSS did not interview or see the SC during the investigation. WCDSS did not attempt face-to-face interviews with the SF or the BM until 06/22/18 when an unannounced home visit was made, 8 weeks after the start of the investigation. WCDSS did not request releases from the parents to speak with service providers so collateral contacts were not made throughout the duration of the case.. Sufficient information was not gathered surrounding the SC’s death. WCDSS did not obtain sufficient information to determine whether there were surviving siblings or other children living in the home. WCDSS assessed the safety of the SC within 24 hours and made efforts to see SC, but the BM prevented contact.

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

Issue:
Adequacy of Child Protective Services casework contacts

Summary:
Casework contacts did not include one face-to-face home visit with the subject, other persons, or child named in the report. WCDSS did not make reasonable efforts to achieve another type of contact in the absence of face-to-face contact, which could have included phone or written contact. Due to the lack of casework contacts, WCDSS was unable to assess whether there was a need for services.

Legal Reference:
432.2(b)(4)(vi)

Action:
Before making a determination, WCDSS must make a minimum of one home visit with face-to-face contact with subjects and other persons named in the report and children named in the report.

PIP Requirement:
WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:

The case record did not reflect how WCDSS gathered information to make the determination. The determination noted SC's MH treatment as well as school attendance, but there was no documentation in the case record or external files to support the statements. The determination stated BM refused to sign releases, but it wasn't documented that either parent was asked to sign releases.

Legal Reference:

18 NYCRR 428.5(a) and (c)

Action:

Documentation within the case record must include caseworker efforts to explore and elicit information in gathering and analyzing safety and risk factors in determining the allegations.

PIP Requirement:

WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Issue:

Adequacy of services following the fatality

Summary:

BM was not contacted following the fatality in an effort to explore potential for service needs.

Legal Reference:

18 NYCRR 432.2(b)(4);428.6

Action:

WCDSS will explore areas of potential service needs with all family members with whom they are involved. WCDSS will appropriately respond to changing circumstances, and if service needs are identified, WCDSS will make the appropriate referral to preventive or community-based services in an effort to determine whether there are services that can benefit the family.

PIP Requirement:

WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Issue:

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

Summary:

The allegation of IG against the subject father was not addressed.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(d)

Action:

WCDSS will refer to the CPS Program Manual and/or consult with the Spring Valley Regional Office when determining the appropriateness of allegations. WCDSS will fully explore the extent of what is alleged as it pertains to the safety and risk to the allegedly maltreated child.

PIP Requirement:

WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

There were missed opportunities to gather collateral information, such as the school where the SC was a student, the MH counselor the SC saw just days before her death, and a discharge summary from the hospital where child was inpatient.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

WCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

PIP Requirement:

WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going concerns.

Issue:

Review of CPS History

Summary:

There was no documentation of an SCR history check for the family within one business day. WCDSS did not review CPS history until 5 days after the receipt of the report.

Legal Reference:

18 NYCRR 432.2(b)(3)(i)

Action:

Within one business day, WCDSS will review SCR records pertaining to all prior reports involving members of the family, including legally sealed unfounded reports where the current report involves a subject of the unfounded report, a child named in the unfounded report or a child's sibling named in the unfounded report. The history check should be documented in progress notes accordingly.

PIP Requirement:

WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going concerns.

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

10/28/2013: UNF against BM for IG regarding the SC.

Known CPS History Outside of NYS

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

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

WCDSS takes every CPS report serious, and diligently seeks to engage families, ensure safety, and promote wellbeing at all stages. The tragic death of a child is always extremely difficult and requires a thorough case review to assess and continually improve practice.

While report SV-18-041 summarizes the Department's, work investigating an allegation of IG, it does not fully represent the complexity, challenges, and efforts of WCDSS to engage the family prior to the death of their child by suicide, and respect for their needs and rights following her death.

The SC in this case lived with her BM, with no siblings, and had been hospitalized as an inpatient in a mental health facility. WCDSS assessed safety within 24 hours, spoke with the BM and the hospital, and attempted to visit the child and access information from the BM and mental health providers during her hospitalization and following her return home, but the BM asserted her right to privacy and denied access to the SC and records.

Despite that, following legal consultation and advice, WCDSS continued efforts to engage the family, visit the child, and obtain additional information. At no point during the investigation did WCDSS identify specific concerns regarding the BM's supervision or care for the SC, and respected her right to privacy following the SC's death and the Department's determination.

As requested, a PIP will be submitted to further correct any report inaccuracies and address any identified compliance issues.

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