Child Fatality Report

Report Identification Number: SV-16-040

Prepared by: Spring Valley Regional Office

Issue Date: Feb 23, 2017

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 13 year(s)
Jurisdiction: Nassau
Gender: Male
Date of Death: 09/24/2016
Initial Date OCFS Notified: 09/26/2016

Presenting Information

This report was called in to the New York Statewide Central Register of Child Abuse and Maltreatment regarding the mother listing allegations of Emotional Neglect, DOA/Fatality, Inadequate Food/Clothing/Shelter, Inadequate Guardianship, Lack of Medical Care and Lack of Supervision on behalf of the 13-year-old male subject child. This report alleged the mother had a history of verbally degrading the subject child causing him to become unstable and experience suicidal ideations and self-harming behaviors. The mother was noted to have been aware of the subject child's mental health issues, however failed to seek any mental health treatment, continued to verbally degrade him, physically hit him, and frequently leave him alone and unattended for multiple hours a day. On 9/24/2016, the subject child committed suicide by hanging himself with a hose in the family shower after being left alone for approximately eleven hours.

Executive Summary

The investigation revealed that on 9/24/2016, the mother overheard the subject child talking on the telephone with one of his friends regarding plans for the evening. The mother explained this friend told the subject child not to come to hang out with him as he was with other kids who do not like him. When the subject child hung up the phone, he was “wailing” and screamed a “heart-wrenching” cry. The subject child eventually settled down, and he and the mother spend the rest of the afternoon separately in their own rooms watching television. The mother had evening plans to go to a housewarming party and had soup with the subject child before leaving. They made plans to watch a movie when she returned, and she left for the party at 7:00 PM. At 9:00 PM, the mother returned home and found the subject child facing the wall, hanging in the shower. The mother took the subject child down, and lied the subject child in the bathtub and began to administer CPR. The subject child vomited a little, and she ran outside for help. Local law enforcement officials and EMS responded to the home and the subject child was transported to the local hospital where he was pronounced dead at 10:07 PM.

An autopsy was performed on the subject child on 9/26/2016. As per the Medical Examiner, the subject child had no marks and/or bruises indicative of abuse or neglect. The Medical Examiner ruled the subject child’s death a suicide and the cause of death as Asphyxia due to hanging. The District Attorney’s Office was not involved as local law enforcement officials conducted an investigation and noted no criminality. Detectives also determined the case was a suicide and no arrests or charges were made. The father was not actively involved in the subject child’s life and disclosed he only saw the subject child approximately a “half a dozen” times a year. The parents have no other children and there were no minor children residing in the home.

All of the allegations listed on the report were unsubstantiated regarding the mother on behalf of the subject child. Collateral contact with the subject child’s pediatrician and school personnel corroborated the mothers story that there was no prior indication the subject child would harm himself. A note the subject child had written was found by the mother approximately one-month prior to the incident. The note explained that the subject child was being bullied on the bus and at school and was cutting. The mother believed the note was old as the subject child was no longer taking the bus and she, nor the pediatrician observed any self-injurious marks on the subject child, so the mother assumed the cutting was in reference to missing classes at school. School personnel also stated that the mother was proactive and expressed genuine concern for the subject child.

Appropriate service referrals were offered to the mother. At the time of case closure, the mother was engaged in bereavement services and was active in her church. Additional service referrals were provided to the mother for support groups regarding suicide, however she declined. The case was closed on 10/28/2016.

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?** 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

Explain:
The decision to close the case as unfounded was appropriate. There were no surviving siblings or other minor children residing in the household.

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 as unfounded was appropriate.

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: 09/24/2016 **Time of Death:** 10:07 PM

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

County where fatality incident occurred: NASSAU

Was 911 or local emergency number called? Yes

Time of Call: Unknown
Did EMS to 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: Suicide

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	13 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	52 Year(s)
Other Household 1	Father	No Role	Male	54 Year(s)

LDSS Response

Nassau County Department of Social Services, (NCDSS), conducted an investigation into the allegations listed on the report. NCDSS made appropriate collateral contacts including the local law enforcement officials, hospital staff, the Medical Examiner, relatives, neighbors and community resources. The subject mother was interviewed and observed, and the allegations were discussed. Appropriate service referrals were offered to the mother, however declined.

The father was not very involved in the subject child's life and disclosed he only saw the subject child approximately a "half a dozen" times per year. The father did not reside in the home. The mother and father had no other children and there were no minor children residing in the home. NCDSS completed all safety assessments accordingly. No risk assessment profile (RAP) was submitted. The case notes were well documented, detailed and contemporaneous.

The mother called 911 and the subject child was transported to the local hospital via ambulance. He was pronounced dead at 10:07 PM. Prior pediatric records indicated no evidence of any trauma or other injury indicative of abuse or neglect was observed. The pediatrician also stated that the mother or subject child did not mention any mental health concerns, and there were no signs of cutting behaviors observed. School personnel also stated that the mother was attentive and expressed genuine concern for the subject child. It was also noted that the subject child showed no signs of Depression or suicidal ideations.

Local law enforcement officials explained that there was no criminality, and no arrests were made as a result. The District Attorney's Office was not involved. During their investigation, local law enforcement officials also determined the incident to have been a suicide. The Medical Examiner noted the subject child has no marks and/or bruises, and ruled the death as a suicide. The cause of death was Asphyxia due to hanging.

There was documentation of supervisory conferences noted in which the circumstances of the case were discussed and directives were provided. The CPS investigation was closed on 10/28/2016 and the allegations on the report were unsubstantiated regarding the mother on behalf of the subject child for Emotional Neglect, DOA/Fatality, Inadequate Food, Clothing, Shelter, Inadequate Guardianship, Lack of Medical Care, and Lack of Supervision. Appropriate service referrals were provided to the mother regarding support groups for suicide. The mother was engaged in bereavement counseling and was active in her church. As per the mother, these were all the she needed.

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
Comments: The fatality investigation was conducted by an MDT team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: A CFRT meeting was held on 10/11/2016. There was no DA involvement. Local law enforcement officials found no criminality, and the subject child's death was ruled a suicide. There were also no referrals made to the caseworker.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
035101 - Deceased Child, Male, 13 Yrs	035102 - Mother, Female, 52 Year(s)	Emotional Neglect	Unsubstantiated
035101 - Deceased Child, Male, 13 Yrs	035102 - Mother, Female, 52 Year(s)	Lack of Supervision	Unsubstantiated
035101 - Deceased Child, Male, 13 Yrs	035102 - Mother, Female, 52 Year(s)	DOA / Fatality	Unsubstantiated
035101 - Deceased Child, Male, 13 Yrs	035102 - Mother, Female, 52 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
035101 - Deceased Child, Male, 13 Yrs	035102 - Mother, Female, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
035101 - Deceased Child, Male, 13 Yrs	035102 - Mother, Female, 52 Year(s)	Lack of Medical Care	Unsubstantiated

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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:
Emergency room personnel was not contacted, however given the circumstances of the case, was not needed.

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	Needed but not Offered	Needed but Unavaliable	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:
The mother was engaged in bereavement services, was active in her church, and declined the bereavement services offered to her by the Caseworker. As per the mother, this was enough, and she did not feel she needed additional services. The caseworker provided the mother with referrals for various support groups.

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? N/A
Explain:
There were no siblings or other children residing in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
As per the mother, she was engaged in bereavement counseling and was very active in her church. Service referrals were also provided to the mother for different support groups regarding coping with suicide.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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? N/A

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

The mother is listed as a subject on a case called in on 12/1/2007. The report was indicated, however the allegations of Child's Drug/Alcohol Misuse, Inadequate Food/Clothing/Shelter, Inadequate Guardianship and Inadequate Food, Clothing, Shelter, Lack of Medical Care, Lack of Supervision and Sexual Abuse regarding the mother on behalf of a child residing in the home unrelated to her, were unsubstantiated. The subject child was also listed on the report, however he was listed as having no role.

Known CPS History Outside of NYS

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

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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

No additional local district comments.

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