Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-19-016

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

Issue Date: Jul 16, 2019

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: 17 year(s)
Jurisdiction: Nassau
Gender: Female
Date of Death: 04/13/2019
Initial Date OCFS Notified: 04/17/2019

Presenting Information

An SCR report alleged the 17-year-old child's father had a history of being physically aggressive toward her. It was reported that on 4/13/2019, the father physically assaulted the teen, resulting in her death. Further details of the death were unknown, including any injuries. The roles of the father's partner (a parent substitute) and the child's mother were unknown.

Executive Summary

This fatality report concerns the death of a 17-year-old female, whose death was reported to the SCR as suspicious of abuse or neglect. Allegations concerning the fatality were against her father, with whom she primarily resided. Nassau County Department of Social Services (NCDSS) initiated the investigation, and quickly confirmed with various reliable sources that the child committed suicide four days prior to the county's notification.

Though an autopsy was declined by the family, toxicology tests were completed, the results of which remained pending at the time of this writing. NCDSS was provided a copy of the death certificate, which noted a medical examiner pronounced the manner and cause of death as suicide by hanging.

Law enforcement were among the first responders who aided the family in the father's home after a 911 call was made; the father found the child hanged herself in her room while he was elsewhere in the home, having last seen her alive one-hour prior. NCDSS collaborated with law enforcement and shared information. The child was not described to have bruises or injuries that were indicative of a physical assault, as alleged. Though it was learned early in their involvement that law enforcement found no criminality and were not pursuing an investigation, NCDSS continued to explore whether any abuse or maltreatment contributed to the suicide.

NCDSS was involved with the family at the time of the fatality, as a child protective report was made one-month prior against the teen's mother and father. That report alleged the father was verbally and emotionally abusive toward the child; also, the parents' divorce was said to have negatively impacted her, as they allegedly brought her into their arguments. Prior to her death, NCDSS spoke to the child twice outside the presence of her parents. A counselor she was seeing in the community was also contacted. Though it was evident there was tension within the family, the child denied the extent of what was alleged and there was no indication she was suicidal or mentally unstable. In order to promptly address the allegations in that report, NCDSS made numerous attempts to speak with the parents by various methods, yet comprehensive interviews were only successful after the fatality occurred. NCDSS then learned that although the suicide was not expected, there were underlying factors that may have contributed to the child's despondency. In addition, the child had suicidal ideations the year before and received the appropriate interventions and treatments at that time, which were sought after by the parents and followed through with.

The teen was survived by one sibling, who was 20 years old. There were no other children who resided in either the mother or father's homes. Aside from those mentioned above, NCDSS spoke with collateral contacts with knowledge of the child and family, which included family members, a parent of the teen's friend, and school staff.

NCDSS concluded there was no credible evidence that the child was maltreated, nor did they find any indication her father's actions or inactions contributed to her death. NCDSS provided bereavement referrals to the family, a service in which the mother reportedly partook prior to the investigation's closure.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
Safety assessments were timely and appropriate; however, they were not required as it was determined there were no surviving children. The determination of allegations was appropriate given the supportive evidence in the case.

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 was appropriate. There was evidence of supervisory consultation throughout the case record.

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: 04/13/2019 **Time of Death:** 12:47 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: 12:03 PM

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? Yes
How long before incident was the child last seen by caretaker? 1 Hours
At time of incident supervisor was: Not impaired.

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	17 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	53 Year(s)
Deceased Child's Household	Father's Partner	No Role	Female	55 Year(s)
Other Household 1	Mother	No Role	Female	54 Year(s)

LDSS Response

NCDSS began investigating a CPS report concerning the teen on 3/11/2019, which alleged maltreatment by her parents. She was interviewed at school and was not found to be in immediate or impending danger of serious harm. NCDSS came upon barriers when attempting to interview the father; he wanted his lawyer present, and despite NCDSS extending numerous opportunities to facilitate such interview, one was not held prior to the fatality. On 4/2/2019, the child was seen again, to follow up on the reported concerns and gain further insight on the adults. NCDSS continued to have no success contacting the mother, father, or father's partner.

On 4/17/2019, NCDSS received a call from school staff, informing them the child committed suicide the previous weekend. NCDSS immediately informed their Regional Office and began gathering supplemental information. Later that night, another SCR report was received and a fatality investigation was initiated. NCDSS notified LE and gathered information about their response on the date of the incident. They learned police found no evidence to suspect criminality, nor did they find drugs, alcohol, or other concerns. NCDSS continued communication with LE throughout the investigation.

The next day, NCDSS interviewed the mother and adult sibling. The mother was not present at the time of the incident since it occurred in the father's home, though she shared what she knew about the fatality. The mother was concerned the father was physical during arguments, after the child disclosed to her in January that he was 'mean' and 'got in (her) face.' The mother responded by telling him to stop, and warned him not to put his hands on their child or she would contact police; the child did not report any incidents to her after that time. The mother shared information about the child's MH, but had not suspected she was suicidal. The two had daily contact, and the child aspired for her future. One year prior, she found a noose in the child's room and saw her bed re-positioned under a ceiling fan; the child told her she planned to kill

herself, and the mother immediately arranged for in-patient treatment. NCDSS followed up with providers and confirmed she successfully completed in-patient treatment and out-patient care; recently, she received treatment from her Dr. and a counselor.

NCDSS learned from the father that the evening before the suicide, the child and her friend lied to their parents and went to a hotel. The child used drugs, and the father found out that evening. Along with the friend's parent, they got the children home. This was confirmed with police, as they escorted the child home that night. The father punished her the next day by taking away her phone; they argued and went into separate rooms. The father went to her room an hour later, finding her door locked and barricaded. He got in and found her hanging from a ceiling fan by an extension cord. He immediately got her down and began CPR while the parent substitute called 911. First responders continued CPR; she was transported to the hospital, and pronounced deceased.

The father denied all that was alleged of him in both reports. Despite several attempts to interview the father's partner, including efforts by a neighboring county to visit her new residence, she would not participate in an interview. Brief phone contact was had, where she denied concerns for the father's care or treatment of the child.

Police noted two of the child's prescription bottles were on her bed, and two others were on a kitchen counter; the significance of this was not noted. Since the toxicology results were pending, it was unknown if the child was impaired at the time she committed suicide. There was no concern that either caregiver in the home was impaired.

The family was provided information on bereavement services, which the mother utilized. NCDSS gathered sufficient information and completed all casework activity; the case was unfounded and closed.

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?No
Comments: This fatality has not yet been reviewed by the Nassau County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050641 - Deceased Child, Female, 17 Yrs	050642 - Father, Male, 53 Year(s)	Inadequate Guardianship	Unsubstantiated
050641 - Deceased Child, Female, 17 Yrs	050642 - Father, Male, 53 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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:
Though she was spoken with over the phone, the parent substitute refused an interview or face-to-face meeting. Despite this, NCDSS made numerous efforts to facilitate an interview, to no avail. The source of the fatality investigation was anonymous.

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	☐	☐	☐	☐	☐	☒	☐

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 minor siblings or other children in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Information on bereavement services was provided to both parents. The mother shared that she utilized such service.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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)	Allegation Outcome	Compliance Issue(s)
03/11/2019	Deceased Child, Female, 17 Years	Father, Male, 53 Years	Emotional Neglect	Unsubstantiated	Yes

Deceased Child, Female, 17 Years	Father, Male, 53 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 17 Years	Mother, Female, 54 Years	Emotional Neglect	Unsubstantiated
Deceased Child, Female, 17 Years	Mother, Female, 54 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report alleged the father was emotionally and verbally abusive to the subject child. He would grab her by the face while shouting at her, so close that his spit would hit her in the face. The father called the child degrading names and told her she was “no good.” The child was fearful of her father, had low self-esteem, was withdrawn and anxious, and slept a lot. Her parents were involved in a toxic divorce and would bring the child into their arguments, which upset her and caused her an extremely stressful situation.

Report Determination: Unfounded | **Date of Determination:** 05/15/2019

Basis for Determination:
The child was interviewed on more than one occasion and denied what was alleged in the report, but confirmed her father had gotten in her face while yelling. She stated they were both working on walking away from each other during arguments. The father denied all that was alleged, though the mother believed it to be true. The child was attending therapy, addressing prior sexual assaults and family discord. Though NCDSS found she had a history of suicidal threats and ideations, she was receiving treatment and had received it in the past; additionally, the parents had no reason to suspect she was currently suicidal. NCDSS investigated information upon learning of the child's death.

OCFS Review Results:
Many efforts were made to interview the father promptly upon receipt of the SCR report, though he wanted to meet through his lawyer and this created scheduling barriers. Despite NCDSS’ efforts to interview both parents prior to this occurrence, contact was not had with either of them until after the fatality. NCDSS began an investigation into the fatality upon learning the information, and upon receiving a fatality report from the SCR. An abundance of collateral information was gathered and evaluated with respect to the final determination.

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

Issue:
Failure to provide notice of report

Summary:
The mother and parent substitute were not provided written Notice of Existence letters.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
NCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. In the event other adults are later added to the case, they will be notified in writing as well.

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

Two historical cases existed for the family more than three years prior to the fatality. An investigation from 7/13/2009 through 9/1/2009 was unfounded. The allegations were IG and L/B/W against the mother concerning the subject child; these allegations were unsubstantiated. An investigation from 12/2/2010 through 2/14/2011 was indicated against the father regarding a 12-year-old sibling (who is now an adult). The substantiated allegations against him were XCP, IG, and L/B/W; S/D/S was unsubstantiated.

Known CPS History Outside of NYS

There was 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

Nassau County recognizes that an oversight was made regarding the notice of existence to adults which were not named in the report, but were added later.

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