Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-19-004

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

Issue Date: Jun 20, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 15 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 01/17/2019
Initial Date OCFS Notified: 01/18/2019

Presenting Information

An SCR report was received that alleged the 15-year-old child shot himself on 1/16/19, and was taken by EMS to the hospital. The child died on 1/17/19 due to a self-inflicted gunshot wound to the right side of his head. The child was aware the father had a laoded handgun that was not locked away, and the child had access to the firearm. The child used this gun to shoot himself. The role of the mother was unknown.

Executive Summary

This fatality report concerns the death of a 15-year-old male child that occurred on 1/17/19. Two reports were made to the SCR regarding this: The first on 1/16/19, when the child was hospitalized and on life support due to his fatal injuries, and the second on 1/18/19, after the child was declared deceased. The fatality report was received with allegations of Inadequate Guardianship and DOA/Fatality against the child's father. Monroe County Department of Human Services (MCDHS) completed a thorough investigation into the fatality and the preceding events. The final autopsy report noted the cause of death as "complications of gunshot wound of the head," and the manner as suicide.

At the time of the fatal incident, the child resided with his mother and step-father, but spent evenings and weekends with his father. The child had an adult sibling; however, there were no other children in either household. On 1/16/18, the father picked the child up around 4:15 PM and the two went back to the father's house. The father reported the child was acting normally, played video games and completed his homework. The two had dinner and around 8:15 PM, the father had to return the child to his mother's house for the night. The father got into his car in the driveway, and the child placed his belongings in the back seat. The child then said he forgot his cell phone in the house, and went inside to retrieve it. Approximately 3 to 4 minutes later, the child still had not returned. The father went inside to check on the child and found him unresponsive and bleeding on his bedroom floor. It was discovered the child had shot himself in the head with one of his father's handguns, which was stored loaded in the father's nightstand drawer. The father called emergency services, who arrived shortly after and transported the child to the hospital. The child was admitted and medical staff performed numerous medical tests. Hospital physicians reported the child's injuries were non-survivable, and on 1/17/19, the child was declared brain dead; the family chose to have the child's organs donated.

From the time the investigation began to the time of its closure, MCDHS met with and interviewed both parents, the step-father, and the adult sibling. All family members expressed there were no signs the child was depressed or suicidal. The father had several guns in his home, and kept all but one handgun locked away; this was in his nightstand for protection. The child was educated surrounding gun safety and how to handle a firearm. The child had never gone near any of the father's guns unsupervised in the past. MCDHS spoke at length with numerous collateral sources, including the child's teachers, school social worker and pediatrician. There were no concerns surrounding possible mental health issues or suicidality noted by any of the collateral sources. Law enforcement was involved but there were no charges filed against the father. MCDHS offered services to the family, unsubstantiated the allegations and closed the case.

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:
The decision to unsubstantiate the allegations was appropriate. There were no surviving siblings or other children 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:
MCDHS exhibited best casework practice throughout this investigation. The decision to close the case 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: 01/17/2019 **Time of Death:** 05:47 PM

Date of fatal incident, if different than date of death: 01/16/2019
Time of fatal incident, if different than time of death: 08:30 PM

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 08:33 PM
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: Went inside to retrieve cell phone.

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 4 Minutes
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	Male	15 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	56 Year(s)
Other Household 1	Mother	No Role	Female	48 Year(s)

LDSS Response

On 1/16/19, an SCR report was received regarding the child's self-inflicted gunshot wound to the head. The child was still alive at the time this report was made, but it was understood by the family and MCDHS that the child would not survive his injuries. On 1/17/19, the child was declared brain dead, and on 1/18/19, the MCDHS received the SCR reported fatality.

On 1/16/19, MCDHS completed thorough interviews with the mother, father, step-father and the adult sibling at the hospital where the child had been admitted. All family members reported the child showed no signs of depression or other mental health concerns, nor did anyone have any concerns he may have been suicidal. The parents denied the child was bullied at school; however, the child did have learning disabilities that required him to have an IEP. Both parents stated the child's only frustrations were his learning disabilities, but he would speak of his future and plans to join the Army. All family members denied concerns surrounding substance use and stated the only form of discipline used was taking the child's gaming system away. The parents explained the child had some friends from school; however, most of his friends were from online gaming.

The father was interviewed surrounding the events leading up to the suicide. The father explained the child would visit him at his home nightly. He reported on the day of the incident, he picked the child up around 4:15 PM, and the two were joking in the car on the way to the house. The father stated the child played video games when they arrived and the father ordered pizza for dinner; nothing out of the ordinary occurred, and the father reported the child was acting like himself. Around 7:30 PM, the father reminded the child to finish his homework, and at 8:15 PM, it was time to take the child back to his mother's. The father stated the two went to the car, but the child said he forgot his cell phone in the house. The father gave the child the key to the house to retrieve his phone. After 3-4 minutes, the father went to check on where the child was. He stated he called his name and then went upstairs, finding the child laying on his bedroom floor bleeding. He stated he immediately called 911. The father reported he had several guns in the home and had all but one locked in a gun cabinet. The father explained he was a corrections officer, and kept one loaded gun in his nightstand drawer for protection. He stated the child had been fully trained on gun safety and knew not to touch a gun unsupervised; the child knew the father kept a gun in his nightstand. The father explained the child never touched the gun in the past and he had no concerns the child would try to use the gun. The other family members also denied any concerns the child would touch one of the father's guns. The mother and step-father's account of the events corroborated the father's story. Both the mother and

father reported the child had not been acting any differently in the days leading up to his death, and the child seemed happy and his normal self.

Throughout the investigation, MCDHS spoke at length with law enforcement and hospital staff regarding events leading up to the child's hospitalization and death, and medical records were obtained. Law enforcement informed MCDHS the child left a suicide note in the bedroom. Law enforcement stated they found no criminality and there would be no charges against the father. MCDHS followed up with the child's pediatrician, teachers and school social worker, and they concurred there were no signs the child was distressed or suicidal. MCHDS offered all family members appropriate services, which were accepted. The allegations were unsubstantiated and the case was 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
Comments: This fatality investigation was conducted by the Monroe County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Monroe County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050363 - Deceased Child, Male, 15 Yrs	050364 - Father, Male, 56 Year(s)	Inadequate Guardianship	Unsubstantiated
050363 - Deceased Child, Male, 15 Yrs	050364 - Father, Male, 56 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?	☒	☐	☐	☐
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:
MCDHS spoke with all family members as well as appropriate collateral sources. All progress notes and other required documentation were entered timely.

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:
MCDHS provided the parents appropriate service referrals, and they began attending counseling appointments during the investigation. The record did not reflect if funeral assistance was offered. There were no other documented service needs for the family.

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 other children under the age of 18 that resided in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS assisted the parents with setting up grief counseling. MCDHS also offered the adult sibling and step-father service referrals.

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?	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 was 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