Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-19-018

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

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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: 16 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 05/22/2019
Initial Date OCFS Notified: 05/28/2019

Presenting Information

An SCR report was received with concerns on 5/23/19, the 16-year-old subject child took her own life because she was not receiving adequate mental health treatment. The child's parents were aware the child had a history of suicidal ideations but did not acknowledge the severity of such. The adult sibling had an unknown role.

Executive Summary

This fatality report concerns the death of a 16-year-old female subject child (SC) that occurred on 5/23/19. A report was made to the SCR on 5/28/19 with allegations of Inadequate Guardianship, Lack of Medical Care and DOA/Fatality against the child's mother (SM) and father (SF). Monroe County Department of Human Services (MCDHS) received the report and investigated the child's death. An autopsy was completed; however, the official report was not yet available at the time of this writing. A preliminary report noted the cause of death as suffocation and the manner of death as suicide.

At the time of the child's death, she resided with her mother, father, and adult sibling. The investigation revealed the mother was out of town when the incident occurred, but the father and sibling were home. The father last saw the child at approximately 9:30 PM on 5/22/19, and the sibling last heard the child walking around her room around 11:15 PM that night. The father awoke at 6:30 AM the next morning and went into the child's room to wake her for school. At that time, the father found the child on her bed with a bag and sweatshirt tied around her head and face, unresponsive. Emergency services were called and the child was pronounced deceased at the scene. Although it was revealed the child had a lengthy history of serious mental health concerns, neither the mother, father nor brother reported anything out of the ordinary in the days and hours leading up to the child's suicide.

From the time the investigation began to the time of its closure, MCDHS met with all family members and interviewed pertinent collateral sources. Law enforcement completed an investigation and their findings corroborated the information the family provided to MCDHS. There was no evidence abuse or maltreatment led to the death of the child; therefore, the allegations were unsubstantiated and the case was closed to community-based services.

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:
MCDHS gathered sufficient information to appropriately determine the allegations. There were no surviving siblings or other children in the household, therefore a safety assessment was not required.

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 case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

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: 05/22/2019 **Time of Death:** 06:46 AM

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

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 06:32 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? 7 Hours
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	16 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	52 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	52 Year(s)

LDSS Response

On 5/28/19, MCDHS received the SCR report regarding the death of SC, which occurred on 5/23/19. MCDHS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. MCDHS learned LE had been investigating the suicide since the date it occurred, and there were no other children in the household.

On 5/28/19, MCDHS met with SM, SF and the adult sibling in their home. SM reported she was out of state for work at the time of SC's death. SM explained SF informed her he found SC the morning of 5/23/19 in her bedroom with a bag over her head. SM stated the adult sibling was asleep when this occurred. SM reported SC had a history of suicide attempts and ideations. She stated in the past, there were signs SC was feeling suicidal, but there were no inclinations of such leading up to SC's death. SM explained SC was heavily involved in mental health treatment and she had been diagnosed with several clinical issues at a young age. SF joined the conversation and explained the events that led up to the incident. SF stated the night of 5/22/19, SM left to go out of town. He stated SC had worked on her homework until about 7:00 PM and then went to her brother's room to watch videos. SF explained he prompted SC to start getting ready for bed around 9:30 PM that night, and he set his alarm for 6:30 AM to wake her for school because SC would often forget to set hers. SF stated he went to bed and the next morning he awoke to his alarm. SF reported he went to SC's room to wake her and found her on her bed with a plastic bag over her head and a hooded sweatshirt tied tightly around her face. SF said he tried to take the bag off and woke up his son. He stated he then called 911 and SM. The adult sibling was also interviewed on this date and explained there was nothing unusual the night prior to SC's death. He reported he watched videos on his computer with SC and then she went to her room for the night. The sibling explained he last heard SC walking around her bedroom around 11:15 PM and then he went to bed. The sibling stated he awoke to chaos; SF was screaming and not making sense. The sibling stated he saw SC and the bottom of her feet were purple. The family reported they knew to check SC's social media accounts regularly for any hints she was feeling depressed, and she was never left alone for longer than one hour. They explained SC had a history of impulsive and risky behaviors. All family members reported SC was compliant with her mental health treatment and all denied there being any outward signs that SC was considering suicide.

On 5/30/19, MCDHS spoke at length with SC's primary mental health provider. The provider had no concerns surrounding the care the parents provided SC, and reported the parents and adult sibling had done everything they could have regarding SC's mental health treatment. The provider explained SC "covered up her mental illness well" and was prescribed numerous psychotropic medications. There were recent concerns SC was beginning to have episodes of psychosis and hearing voices, but SC would always give a "red flag" before attempting any self-harm. The provider reported this time there were no warning signs.

Throughout the investigation, MCDHS spoke with collateral sources, including SC's pediatrician, school, LE and EMS.

MCDHS offered the family appropriate services in response to the fatality, and LE found no criminality regarding SC's death. MCDHS found no evidence to support the allegations received in the report and therefore unfounded and closed the case.

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
051768 - Deceased Child, Female, 16 Yrs	051769 - Mother, Female, 52 Year(s)	DOA / Fatality	Unsubstantiated
051768 - Deceased Child, Female, 16 Yrs	051770 - Father, Male, 52 Year(s)	DOA / Fatality	Unsubstantiated
051768 - Deceased Child, Female, 16 Yrs	051770 - Father, Male, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
051768 - Deceased Child, Female, 16 Yrs	051769 - Mother, Female, 52 Year(s)	Lack of Medical Care	Unsubstantiated
051768 - Deceased Child, Female, 16 Yrs	051769 - Mother, Female, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
051768 - Deceased Child, Female, 16 Yrs	051770 - Father, Male, 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?	☒	☐	☐	☐

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 household members and all appropriate collateral sources. Progress notes and all other documentation was 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:
Although MCDHS provided the family with appropriate service referrals, they were already engaged in individual and family counseling with an independent provider.

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 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 provided referrals for bereavement counseling to the parents and adult sibling; however, they were already engaged with individual and family counseling in their community.

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