Child Fatality Report

Report Identification Number: BU-17-006

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

Issue Date: Jul 07, 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: Erie
Gender: Male
Date of Death: 03/20/2017
Initial Date OCFS Notified: 03/20/2017

Presenting Information

The SCR report alleged the 13-year-old male SC committed suicide and was found hanging in his room by the 16-year-old male SS. The SC had expressed suicidal ideation over the past month and the SF was aware. For this reason, the SC was a child in need of a higher level of supervision. Despite the SF being present in the home, he did not check on the SC, who was alone in his room, for one and a half hours. It was alleged the lack of supervision contributed to the SC's death. Additionally, the report stated the home was in deplorable condition, being unsanitary from garbage in the home.

Executive Summary

This report concerns the death of the 13-year-old male SC, who was reported to have died as a result of suicide. Erie County Department of Social Services (ECDSS) was assigned to investigate the death as a result of a report received by the SCR on 3/20/2017. ECDSS investigated the allegation that the SF's inactions contributed to the SC's death, by his failure to adequately supervise the SC after knowing he was suicidal.

The SC was found by the 16-year-old SS after the SC had been alone in his room for approximately two hours. The SS entered the SC's room and found the SS had hung himself. Resuscitative measures were performed by the SS, as well as EMS following a 911 call, but efforts were unsuccessful. The SC was pronounced deceased at the home.

Within 24 hours of the report, ECDSS determined in the safety assessment that the SS was not in any immediate danger. ECDSS did identify through conversations with the SS that the SS had experienced death-related situations in the past with all of his family members, even being witness to his mother's death in 2011. ECDSS was diligent in offering services and had both the SF and SS screened for a MH assessment. Though the SS was referred by the clinical specialist for a MH evaluation, the SS refused. The SF was made aware of the recommendation and the SS's decision, and agreed to keep the option open should the SS change his mind. SS expressed not having any suicidal or homicidal ideations of his own. ECDSS followed up with the SS and the SS discussed alternative supports he found more beneficial than therapy. ECDSS provided the family with resource information for services in the event they chose to utilize services in the future.

The ME's autopsy report confirmed the SC's injuries were indicative of strangulation by use of a cloth belt, and noted linear scars on his forearm consistent with self-inflicted cuts. The cause of the SC's death was asphyxia due to hanging and the manner of death was suicide.

In interviews with the SF, SS, family members, and the two other non-relative adults residing in the home, ECDSS determined there was no credible evidence that the SF was aware of the SC's suicidal ideations or could have prevented the death. Due to the fact that the SC was not known to have previously exhibited any behaviors indicative of mental distress to the SF, it was clear that the SF would have had no reason to increase his level of supervision or get the child into mental health counseling. For these reasons, ECDSS unsubstantiated all allegations against the SF pertaining to the fatality. ECDSS also unsubstantiated the allegations regarding the condition of the home posing a safety hazard to the children, as it was found to have met minimal standards.

The criminal investigation was closed, and the SC's death was classified as a suicide. There were no arrests related to the fatality based on the ME's findings and the autopsy report.

ECDSS' actions and decisions during this investigation were satisfactory, appropriate, and reflective of best casework practices.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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:
All safety assessments were timely and accurately reflected the case circumstances with regard to the safety of the children.

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 had detailed notes regarding case conferences between the caseworker and supervisor at pertinent points throughout the investigation.

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: 03/20/2017 **Time of Death:** 07:58 PM

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

County where fatality incident occurred: ERIE
Was 911 or local emergency number called? Yes
Time of Call: 07:40 PM
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

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	Alleged Victim	Male	13 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	53 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Female	35 Year(s)
Deceased Child's Household	Unrelated Home Member	No Role	Male	53 Year(s)

LDSS Response

Immediately upon receiving the report, ECDSS spoke with a reliable source and determined the SS was not in any immediate or impending danger of serious harm. Within 24 hours, ECDSS interviewed the family, checked history, coordinated with LE, saw the home, and documented all pertinent information. ECDSS photographed the home and although it appeared cluttered, there were observed to be no safety hazards. Due to the children's ages, the condition of the home did not present an immediate safety concern.

The SF told ECDSS that at approximately 5pm, the SC told him he was going to lie down to sleep in his room. The SF explained the SC was on an odd sleep schedule, often doing homework late at night due to trouble sleeping, and would nap randomly throughout the day. The SF heard the SC come out of his room and talk briefly to the SS about five minutes later, reporting he was having trouble sleeping, but then went back in his room. The SS confirmed this, and the SS was the last person to see the SC alive. Around 7:30 pm, the SS went to tell the SC that he and the SF were going to the store. The SC had the door barricaded from the inside with a mattress, and when the SS broke through the door, he found the SC hanging from a belt fixed to the window. The SS immediately ran outside for the SF, who called 911. The SF told the SS

to perform CPR, as the SF reported to ECDSS he was afraid of hurting the SC. He had performed CPR on his wife prior to her death and had broken her sternum and ribs. The BM passed away in 2011 from natural causes related to medical issues. The SS did perform CPR, as did EMS upon their arrival, to no avail.

ECDSS learned from the SF and SS that the SF was unaware of the SC's suicidal ideations. The SS stated he himself had only learned the day after the SC's death that the SC had made suicidal comments. The SS stated the SC's relationship with a girl had recently ended. ECDSS secured copies of text messages that the SC's ex-girlfriend showed to the SS after the fatality, indicating the SC had sent her messages about wanting to kill himself. ECDSS also observed suicidal statements the SC had recently posted on social media. ECDSS learned the SF and SS were blocked from the SC's social media account, and thus had no knowledge of this. Both SF and SS, as well as other persons who had regular contact with the SC, had no reason to suspect the SC was depressed or suicidal. Other persons interviewed included adult half siblings as well as the two adult unrelated home members who were not present at the time of the fatality. It was corroborated that no one suspected the SC was depressed or suicidal. For these reasons, ECDSS unsubstantiated all allegations against the SF pertaining to the fatality. ECDSS also unsubstantiated the allegations regarding the condition of the home posing a safety hazard to the children, as it was found to have met minimal standards.

ECDSS strongly urged the SF and SS that SS seek MH counseling based on an assessment done during the investigation. Though the SF and SS were resistant to the suggestion, the SS's MH was not deemed a safety concern and ECDSS diligently provided information for services on more than one occasion in an effort to encourage the family.

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: There is no OCFS approved Child Fatality Review Team in Erie County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
038961 - Deceased Child, Male, 13 Yrs	038963 - Father, Male, 53 Year(s)	DOA / Fatality	Unsubstantiated
038961 - Deceased Child, Male, 13 Yrs	038963 - Father, Male, 53 Year(s)	Inadequate Guardianship	Unsubstantiated
038961 - Deceased Child, Male, 13 Yrs	038963 - Father, Male, 53 Year(s)	Lack of Supervision	Unsubstantiated
038961 - Deceased Child, Male, 13 Yrs	038963 - Father, Male, 53 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated

038962 - Sibling, Male, 16 Year(s)	038963 - Father, Male, 53 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
038962 - Sibling, Male, 16 Year(s)	038963 - Father, Male, 53 Year(s)	Inadequate Guardianship	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:

ECDSS interviewed all persons present on the date of the fatality as well as other family and household members. All relevant collaterals were contacted.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local	☐	☒	☐	☐

district?				

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: There was no removal necessary regarding the SS.				

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	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
The SS was evaluated as to the need for a MH assessment per a service referral by ECDSS. When the need was identified, the SS chose not to follow through with the recommendation. ECDSS provided the family with service information if follow-up was chosen in the future.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The SF was evaluated as to the need for a MH assessment per a service referral by ECDSS. No need was identified, but the SF was still referred for grief-related services. ECDSS provided the family with service information if follow-up was chosen in the future.

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? 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? Yes
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)	Status/Outcome	Compliance Issue(s)
04/09/2016	17524 - Sibling, Male, 15 Years	17521 - Father, Male, 52 Years	Inadequate Guardianship	Unfounded	No
	17524 - Sibling, Male, 15 Years	17521 - Father, Male, 52 Years	Lack of Supervision	Unfounded	

Report Summary:
SCR report alleged the SF failed to make a plan for the care of the 15-year-old SS. The SS left the home on 4/5/16 and rode his bicycle 36 miles to a neighboring county. The SS was unsupervised and the SF was unaware of the SS's whereabouts. As a result, the SS was charged with trespassing on private property.

Determination: Unfounded **Date of Determination:** 05/02/2016

Basis for Determination:
ECDSS confirmed that the SS rode his bicycle 31.1 miles on a bike route, but based on separate interviews with the family and collateral contacts, ECDSS found evidence that the SF was aware of this and had approved since the SS had a cell phone to communicate. The SS had said he planned to stay with a friend, and the SS had an adult sibling who lived in the same town as the friend. ECDSS further found that the SF acted appropriately when he found out that the SS had gotten into trouble and went to pick up the SS prior to CPS involvement. ECDSS found no other safety concerns for the SS or SC.

OCFS Review Results:
ECDSS sufficiently investigated the allegations and assessed for other potential areas of abuse or maltreatment. ECDSS consulted administrators when the SF refused entry into the home. When questioned, the children did not reveal any safety concerns for the home or otherwise. ECDSS completed timely and accurate safety and risk assessments. When ECDSS inquired, the SF declined the need for any Preventive Services.

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

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

8/21/07 The allegations of IG, IF/C/S, LS and PD/AM against SF and BM were Unsub regarding 3-year-old SC and two SS, ages 6 and 10. A subsequent report on 9/18/07 was consolidated with the first report.

9/27/10 The allegations of IG and LS were Unsub against SF and BM regarding 7-year-old SC and two SS, ages 9 and 13. LABW was also Unsub regarding the eldest SS.

1/24/11 The allegation of IG was Unsub against SF and BM regarding 7-year-old SC and two SS, ages 10 and 13. BM died of natural causes on the date of the report.

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

We at the Erie County Department of Social Services (ECDSS) find that the facts as written describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality or to the previous investigations. We appreciate the opportunity to partner with OCFS in providing the best possible services to families in our community.

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