Child Fatality Report

Report Identification Number: BU-16-040

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

Issue Date: Mar 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: 14 year(s)
Jurisdiction: Chautauqua
Gender: Male
Date of Death: 11/22/2016
Initial Date OCFS Notified: 11/23/2016

Presenting Information

The 14-year old subject child (SC) committed suicide on November 22,2016 on the front porch of his mother's home. The SC left school early on this day, went to his mother's home and took a gun out of the attic, sat down on the porch with the gun, and fired it at himself. The gun was secured in the attic of the home and the SC was not known to have knowledge of it. The SC did not have a history of mental illness and there were no warning signs of suicide present. The police investigated and no criminal charges were filed. There are two younger surviving siblings (SS).

Executive Summary

On November 22, 2016 the SC took his own life. The SC went to school as usual that morning, he then left school without the knowledge of any school staff, and went to his mother's home. The BM's boyfriend had recently brought guns used for hunting to the home and stored them in the attic, behind a locked door. It is now believed the SC knew how to access these guns, because of his age. The SC opened the lock and had access to a shotgun. The SC sat on the front porch of the home and shot himself in the head using a shotgun he found in the home. A passerby noticed the SC sitting on the porch slumped forward and called 911. The police responded and the SC was pronounced dead on the scene. The BM and BF shared custody of the SC and his two younger SS. BM and BF report that the SC was doing well in school, was well liked by his peers and involved in sports. The school reported the SC to be happy and denied there were ever any discipline issues with the SC at school. The SC had no history of mental health concerns and there were no warning signs that he would take his own life. The SC left no suicide note. There were rumors that the SC's girlfriend ended the relationship recently, and suspicion that something was placed on social media leading up to his death.

On November 22, 2016, CCDSS was notified of the fatality by the BF of the SC during a phone call they made to schedule a home visit. CCDSS then immediately contacted the police, and the police provided CCDSS with the limited information they had. The SCR received notification about a child death in an open CPS investigation. There was no suspicion the SC's death was due to any action, or inaction of the parents, so the information was taken as additional information to an already existing report. The active CPS investigation was regarding allegations of C/T/S and IG against BF regarding a SS. Upon receiving this information, CCDSS immediately assessed the safety of the SS and met with the BM, BF and SS. CCDSS also went to the SC's school and spoke in depth with staff there to ascertain if the SC was having any issues at school. There was no evidence to believe anyone suspected the SC would take his own life. CCDSS offered referrals for bereavement counseling to the family and the family expressed they intended to seek counseling for the SS. CCDSS unsubstantiated the allegations in the open CPS investigation on December 5, 2016. The family and CCDSS agreed the family was not in need of long term 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?** 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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Was the decision to close the case appropriate? No

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:
There is a history of the BF yelling at the children and he also has a history of physical aggression toward the BM but this was not addressed with the BF. The SS expressed her father often grabs her by the face to get her attention and that she is at times fearful of him, but this was never discussed with the father.

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: 11/22/2016 **Time of Death:** Unknown

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

County where fatality incident occurred: CHAUTAUQUA
Was 911 or local emergency number called? Yes
Time of Call: 10:45 AM
Did EMS to 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? 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	No Role	Male	14 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Deceased Child's Household	Mother's Partner	No Role	Male	38 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Other Household 1	Father	No Role	Male	37 Year(s)

LDSS Response

On November 22, 2016 CCDSS immediately contacted local police to verify the death of the SC , after the BF provided this information. CCDSS promptly assessed the safety of the SS. CCDSS made contact with other family members of the SC and school staff, to gather information about the time leading up to the fatality. CCDSS discovered the SC was at school the day of the incident for the first two periods. CCDSS was told the school assumes the SC exited school through the Middle School doors and the school would have no way to monitor if the SC left in between classes. The SC's binder was found on the playground, but no suicide note was left behind. CCDSS determined the SC had no behavior issues at school and was an active and outgoing student with a pleasant demeanor. There was no interview of the SC's friends or alleged former girlfriend. The SC showed no signs of distress in the time preceding the fatality. CCDSS did offer bereavement services and the family was referred to the school for counseling. They received the death certificate as well as police reports.

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: Coroner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐

Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☐	☐	☐	☒
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The information about the child fatality was received during an open CPS investigation, with allegations regarding a SS. The pediatrician for the SC and SS was never contacted during the investigation.

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?	☐	☐	☒	☐

Explain:
The fatality occurred during an open CPS Investigation and the case was closed within 7 days of the fatality. The children were assessed as safe immediately following the fatality, before the case closure.

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☒	☐	☐

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?	☐	☒	☐	☐

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:
Services were offered to the family, the case record did not state whether or not the family accepted these services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
CCDSS gave the parent several resources for counseling and support during their time of grief.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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? 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)	Status/Outcome	Compliance Issue(s)
09/20/2016	13031 - Sibling, Female, 11 Years	13033 - Father, Male, 37 Years	Inadequate Guardianship	Unfounded	Yes
	13031 - Sibling, Female, 11 Years	13033 - Father, Male, 37 Years	Choking / Twisting / Shaking	Unfounded	

Report Summary:
There was an SCR report with allegations of C/T/S and IG against BF regarding the SC's SS (age 10). The report alleged that the BF became angry towards the SS and then choked the child, and pushed her onto the bed. The SS was scared of the father. It was unknown if the SS sustained any injuries. The BM had an unknown role.

Determination: Unfounded	**Date of Determination:** 12/05/2016

Basis for Determination:
The BM and BF shared custody of all the children. CCDSS spoke with both parents and all the children regarding the family dynamics. The BF was yelling for the SS to come downstairs as they were going to be late for SS football game. The SS was having trouble finding part of her uniform and was disrespectful to the BF. The SS reported that the BF did grab her by the chin to get her attention. When the SS turned away, the BF grabbed her by the neck. The SS reported being afraid because BF was yelling at her. The BF stated that he was trying to get SS's attention. The SS had no marks or bruises as a result of the incident. The SS expressed no ongoing fear for the BF or BM.

OCFS Review Results:
CCDSS started the investigation within 24 hours of receiving the report. CCDSS interviewed the children and parents face to face. CCDSS made collateral contacts with the schools and other relatives, but failed to contact any medical staff during the investigation. All Safety Assessments were completed accurately and within set timeframes. The RAP was not completed with accuracy. The BM disclosed that the BF was abusive to her during their marriage. After receiving this information, the BF and his current girlfriend should have been interviewed separately to assess for current domestic violence.

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

Issue:
Timely/Adequate Case Recording/Progress Notes
Summary:
CCDSS entered several progress notes more than 30 days after the event date.
Legal Reference:
18 NYCRR 428.5(a) and (c)
Action:
CCDSS will enter progress notes contemporaneously.

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
CCDSS failed to contact the medical provider the children see for care, or ask the parents for a release of information to do so. The allegations warranted attempting contact with the medical provider.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
CCDSS will make appropriate collateral contacts in the course of an investigation to gather all pertinent information.

Issue:
Overall Completeness and Adequacy of Investigation
Summary:
The BM disclosed that the BF had been physically abusive toward her during their marriage. The PGM also disclosed that although she never witnessed any violence between BF and BM, it was a factor in the divorce. This issue was never addressed with BF during the investigation.
Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)
Action:
CCDSS will fully explore and address all issues that arise during an investigation.

Issue:
Predetermination/Assessment of Current Safety and Risk

Summary:
The element of risk pertaining to DV in the Risk Assessment Profile was never fully explored. The BM disclosed BF was abusive to her during their marriage. The PGM was aware DV was a factor in the divorce of BM and BF. It is unknown if there is ongoing DV between the BF and his girlfriend, because she was not interviewed alone.

Legal Reference:
18 NYCRR 432.1(aa)

Action:
CCDSS will thoroughly evaluate risk during an investigation and accurately record information in The Risk Assessment Profile.

[redacted]

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

This family has no CPS History older than 3 years.

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.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement 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

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☒Yes☐No

Action:	It is recommended that CCDSS work collaboratively with law enforcement to discuss and develop local protocol specific to responding to teen suicide fatalities. In teen suicide cases, there is often speculation that social media may have contributed to the suicide. Interviews with peers can be an effective method in helping to determine the causes and to inform prevention of teen suicide. It is recognized that Child Protective Services (CPS) may face barriers in interviewing collaterals because there is a responsibility to protect confidentiality. Law enforcement may be successfully able to attain useful information from collateral sources and share it with CPS, enhancing the outcome of both investigations.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No