Child Fatality Report

Report Identification Number: SV-19-009

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

Issue Date: Sep 17, 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: Nassau
Gender: Female
Date of Death: 03/21/2019
Initial Date OCFS Notified: 03/26/2019

Presenting Information

A 7065 Reporting Form was submitted which stated on 3/21/19, the child committed suicide by jumping in front of a moving train.

Executive Summary

This fatality report concerns the death of a 15-year-old subject child (SC) that occurred on 3/21/19. The child died during an open CPS investigation that was received by Nassau County Department of Social Services (NCDSS) on 3/13/19 with concerns unrelated to the fatality. An autopsy was not performed, nor was a death certificate obtained, so an official cause and manner of death remained unknown at the time of this writing.

The investigation revealed the child attended dance practice in the city several times a week after school, and utilized the train as transportation; the child would commute via train by herself. NCDSS learned the child had attended dance practice on the evening of 3/21/19, but did not return home when she was supposed to. The family discovered the child took her own life at 11:23 PM by jumping in front of an oncoming train at the train station.

At the time of the child's death, she resided with her mother and three siblings, ages 7, 6, and 3 years old. Family members and numerous collateral sources were interviewed, and there were no reported concerns surrounding the child's mental health or a history of suicidal ideations or attempts. The child was interviewed by NCDSS several days prior to the suicide and there were no concerns of abuse or maltreatment disclosed, nor any suspicion the child may have been depressed or was considering ending her life. The safety of the siblings was assessed on numerous occasions throughout NCDSS' involvement and there were no safety concerns noted. NCDSS offered the family appropriate services in response to the child's death. NCDSS unfounded and closed their initial investigation on 5/15/19.

PIP Requirement
NCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) NCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, NCDSS will review the plan(s) and revise as needed to further address on-going concerns.

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?** N/A

- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
Casework activity was commensurate with the case circumstances. NCDSS offered the family services and closed the investigation that was open at the time SC died.

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 investigation was appropriate.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	Although NCDSS was aware SC was very close to her dance teacher, and SC had texted the teacher shortly before the suicide, NCDSS did not speak with the teacher as a collateral source.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	NCDSS will obtain information from collateral contacts who may have information relevant to the allegations in the report and to the safety of the children.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/21/2019 **Time of Death:** 11:23 PM (Approximate)

County where fatality incident occurred: Nassau
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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: Waiting for train.

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	No Role	Female	15 Year(s)
Deceased Child's Household	Mother	No Role	Female	45 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Other Household 1	Father	No Role	Male	45 Year(s)
Other Household 2	Stepfather	No Role	Male	41 Year(s)

LDSS Response

On 3/22/19, NCDSS submitted a completed 7065 Reporting Form to OCFS regarding the death of SC, which occurred on 3/21/19. At the time of SC's death, there was an ongoing CPS investigation, which began on 3/13/19. This investigation was surrounding concerns BM and the step-father were abusive toward the children, and SC had been sexually abused by her grandfather in the past. In the days preceding SC's death, NCDSS had spoken with all household members and there were no concerns noted regarding the safety of the children: the step-father had moved out of the home prior to CPS involvement, the grandfather was deceased, and none of the children disclosed any type of abuse or maltreatment.

On 3/14/19 and 3/19/19, NCDSS interviewed SC. SC reported she resided with her mother and siblings, and would see her father on some weekends. SC also spoke of attending dance classes in Manhattan three days a week, and traveled to and from her classes alone via train. SC reported to NCDSS that BM was abusive to her and her siblings because she would yell and grab her younger sister by the arm to get her into the car. When asked, SC denied she or any of the SS were ever hit or otherwise unsafe. Although SC reported being unhappy living with BM, she declined wanting to move in with her father because if she did, she would no longer be able to attend dance classes. SC had expressed a desire to move in with her dance instructor; however, SC's parents told SC that was not an option.

On 3/19/19, NCDSS spoke with BM, who reported she and SC's father were going to plan for SC to move in with her father full time. BM also explained she was trying to get SC into mental health counseling to address the conflicts with their relationship; however, it was difficult due to SC's schedule as her only free time was on Tuesday afternoons. NCDSS scheduled a time to meet with both parents on 3/22/19 to further discuss their plan. On 3/22/19, NCDSS received a call from SC's school social worker, who reported SC had taken her life the previous night. Upon learning this information, NCDSS reached out to law enforcement who confirmed SC jumped into an oncoming train and was killed. On this same date, NCDSS met with BM and the SS in their home; the SS were observed to be safe.

On 3/29/19, NCDSS spoke with BF via phone. BF reported he had "so many questions" surrounding why SC would take her own life. On 4/1/19, NCDSS met with the 7 and 6 yo SS at their schools. Neither child expressed any safety concerns, nor did they speak of SC or her death. NCDSS followed up with the school social worker after the interviews, and the social worker had no concerns. On 4/2/19, NCDSS again met with BM in her home; SC's step-father was also present. The BM and step-father denied any concerns surrounding SC or her mental health.

Throughout the investigation. NCDSS spoke with several collateral sources including medical staff, school staff, mental health counselors, and law enforcement; however, the record did not reflect any attempts to speak with SC's dance

instructor as a collateral contact. NCDSS offered all family members appropriate service referrals in response to SC's death. There were no criminal charges brought against BM, BF or the step-father. Family members and collateral sources denied any knowledge that SC may have been depressed or suicidal. NCDSS found no evidence of abuse or maltreatment, and 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 reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Nassau County Child Fatality Review Team.

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?	☐	☒	☐	☐
Other	☐	☒	☐	☐
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:
NCDSS spoke with several collateral sources; however, the record did not reflect SC's dance teacher was spoken to after SC's death. NCDSS was aware the dance teacher was very close with SC and had concerns surrounding her home life.

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 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: This was not an SCR reported fatality.				

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	☒	☐	☐	☐
Explain: NCDSS offered the family appropriate services. The mother accepted referrals, but the father and step-father declined.				

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 children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: None of the surviving children were removed as a result of the fatality.				

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:
NCDSS offered the family appropriate services in response to SC's death, as well as any other services they felt the family needed.

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? Yes
Explain:
NCDSS provided referrals for counseling in response to SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
NCDSS offered the parents and step-father referrals and resources to address their grief and cope with the loss of SC.

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)
03/13/2019	Sibling, Male, 3 Years	Stepfather, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 3 Years	Stepfather, Male, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 3 Years	Stepfather, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 15 Years	Stepfather, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 15 Years	Stepfather, Male, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Female, 15 Years	Stepfather, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 15 Years	Father, Male, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Stepfather, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Stepfather, Male, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 7 Years	Stepfather, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 45 Years	Emotional Neglect	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 15 Years	Mother, Female, 45 Years	Emotional Neglect	Unsubstantiated	
	Deceased Child, Female, 15 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 15 Years	Mother, Female, 45 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Female, 15 Years	Grandparent, Male, 75 Years	Inadequate Guardianship	Unsubstantiated	

Deceased Child, Female, 15 Years	Grandparent, Male, 75 Years	Sexual Abuse	Unsubstantiated
Sibling, Male, 6 Years	Stepfather, Male, 41 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 6 Years	Stepfather, Male, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated
Sibling, Male, 6 Years	Stepfather, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Sibling, Male, 3 Years	Mother, Female, 45 Years	Emotional Neglect	Unsubstantiated
Sibling, Male, 3 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 7 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Female, 7 Years	Mother, Female, 45 Years	Emotional Neglect	Unsubstantiated

Report Summary:
This report was received with concerns the step-father drank in excess and was physically aggressive toward the CHN by shoving and pushing them, which would leave bruises. The report also alleged BM was aware and failed to intervene. Further, the report alleged BM would drag the CHN out of the home and leave them in a car for hours, and would verbally abuse SC. Lastly, the report alleged the grandfather sexually abused SC on an unknown date.

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

Basis for Determination:
NCDSS completed interviews with the parents, SC, and SS. Although SC reported feeling unhappy living with her mother, she did not disclose anything that rose to the level of abuse or maltreatment. The step-father had not lived in the home since January 2019, and denied being intoxicated around the CHN. The grandfather passed away several years prior. The home was observed and no concerns were noted. SC took her own life during this investigation. The allegations were unfounded and closed.

OCFS Review Results:
An MDT approach was not utilized, nor was a forensic interview completed regarding the sex abuse allegation.

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

Issue:
Failure to utilize an approved MDT

Summary:
This investigation included allegations of sex abuse regarding the SC. The record did not reflect law enforcement was notified of the allegation, and a forensic interview was not conducted.

Legal Reference:
SSL 423(6); SSL 424 (5-a); 10-OCFS-LCM-09

Action:
CPS reports with allegations of sex abuse and cases that involve the death of a child, where an LDSS has chosen to establish an OCFS approved multidisciplinary team (MDT), must be investigated by the MDT. In local districts where no MDT has been established, LDSS must jointly investigate the above named CPS cases with law enforcement

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

01/10/2019	Deceased Child, Female, 15 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Female, 7 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Mother, Female, 45 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 7 Years	Stepfather, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 15 Years	Stepfather, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 15 Years	Stepfather, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Female, 7 Years	Stepfather, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Stepfather, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 6 Years	Stepfather, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 3 Years	Stepfather, Male, 41 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 3 Years	Stepfather, Male, 41 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
This report was received with concerns the step-father would arrive home intoxicated and engage in verbal altercations with BM. The report alleged the altercations kept the CHN awake, and they were tired during school as a result.

Report Determination: Unfounded | **Date of Determination:** 02/27/2019

Basis for Determination:
NCDSS interviewed BM, the step-father, and the CHN. Although all of the CHN reported BM and the step-father argued often, none disclosed any abuse or maltreatment in the home, or any negative impact on their schooling. Collateral sources were spoken with and no concerns were noted. By the close of the investigation, the step-father had moved out of the home. NCDSS unfounded and closed the case.

OCFS Review Results:
The record did not reflect any attempts to speak with SC's biological father, or notify him of the investigation.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
The record did not reflect any attempts to interview SC's biological father.

Legal Reference:
432.1 (o)

Action:
NCDSS will make efforts to interview all persons named in a report, face to face, who may have been present during what was alleged in the report, and/or may have information pertinent to the safety and well-being of children that reside in the home, including absent biological parents.

Issue:
Failure to provide notice of report
Summary:
The record does not reflect that a notice of existence letter was sent to SC's biological father.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
NCDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

[redacted]

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

There is no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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

Additional Local District Comments

In reference to the above noted fatality report regarding collateral contact:
The Caseworker attempted to speak with the dance instructor by leaving several voice messages. When the dance instructor finally returned the call, she herself left a voice message “stating that her privacy needed to be respected and she would not speak with the caseworker.” The caseworker played the message in the unit but neglected to document the phone call.
Workers will be reminded to document all calls.

Regarding MDT approach:
The investigation began on 3/13/19 and the SC committed Suicide on 3/21/19. This is a period of 7 days. During this time, there was no disclosure of sex abuse by the child, the child disclosed that the grandfather was deceased. Special Victims Unit was informed and notified at the onset of the case – which is the protocol. Due to the uniqueness of the situation, the MTA (law enforcement) was involved in this case and SVU took a back seat due to the non-disclosure of sex abuse. Case was discussed with SVU but was not documented in the case record. All cases in the sex abuse unit with sex abuse allegations are discussed in the MDT meetings which are held every two weeks. Due to the time frame of this case, notes did not make it into the record.

Regarding lack of attempts to speak with bio dad in past case:
Nassau remind workers to send out notices and to interview absent parents.

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