Child Fatality Report

Report Identification Number: SY-18-025

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		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Tompkins
Gender: Female
Date of Death: 06/06/2018
Initial Date OCFS Notified: 06/21/2018

Presenting Information

On 6/19/2018, Tompkins County Department of Social Services (TCDSS) became aware of the death of three children with whom they had been working in an open Family Assessment Response case. The children died on 6/6/2018 in Laclede County in the state of Missouri. The cause of death for the children was suffocation due to smoke inhalation as a result of a residential fire, according to a contact with Child Protective Services in Missouri.

Executive Summary

This fatality report concerns the death of the 2-year-old subject child, and references the death of her two siblings, ages 1 and 5 years, which occurred on the same date. At the time of the children's death, TCDSS was in the process of closing a Family Assessment Response case with the family, as the children and their mother had moved out of state approximately one month prior. TCDSS was concluding casework activity when they learned the children perished in a house fire on 6/6/2018 in Laclede County, Missouri.

Though they had been living with their mother in Tompkins County for less than one year in response to fleeing from domestic violence, the children were court-ordered to return to Laclede County in late April, 2018. The mother decided to stay in Missouri as well, so she could participate in visitation.

The morning of the residential fire, the three children, their paternal aunt, and their two cousins (one age 6 months, and one age 1 year) were asleep in their home. The children's father had left earlier that morning for work. Records showed a fire originated in the living room/common area of the home. There were no working smoke detectors in the home. The fire department received notification of a structure fire and responded to the mobile home, where they found heavy fire and smoke visible in the middle of the trailer, as well as visible fire coming from multiple windows and the front door. The five children and one adult were removed from the home, although the paternal aunt was the only survivor. She suffered life-threatening injuries, and remained in a coma in the hospital for the majority of TCDSS' involvement. Records indicated all five children died of asphyxiation caused by smoke inhalation.

TCDSS appropriately inquired of all essential collaterals as to whether there was reason to suspect the deaths were a result of abuse or maltreatment. This included interviews, and gathering information and documents via the Missouri Department of Social Services. TCDSS learned Missouri's Child Fatality Review Board examined the circumstances of the fatality and found no reason to suspect such. Facts gathered by TCDSS resulted in the same conclusion.

There was no arrest associated with the event. Individual investigations were conducted by the state Fire Marshal, local Fire Marshal, and the Federal Bureau of Alcohol, Tobacco and Firearms. None of the investigations could conclude an exact cause of the fire; however, there was no evidence of an electrical fire or an accelerant having been used.

There were no surviving children in the parents' care. TCDSS reached out to the mother by phone to extend condolences and aid in any way possible. TCDSS inquired of the Missouri Department of Social Services about extending the offering of services to the father; however, TCDSS was informed the children's mother, father, and the father of the cousins had already been offered grief counseling and provided monetary support in response to the fatalities. The mother remained residing in Missouri, which was where the father lived as well. As there were no further services to be provided by TCDSS, the Family Assessment Response case was closed.

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:
The open CPS case at the time of the child fatalities was a Family Assessment Response case; therefore, there was no determination of allegations, per regulatory procedure.

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 case was appropriate, given the circumstance that all children had died, and TCDSS gathered all necessary information.

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: 06/06/2018 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 09:00 AM

Was 911 or local emergency number called? Yes
Time of Call: 09:09 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
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 5
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	2 Year(s)
Deceased Child's Household	Father	No Role	Male	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Mother	No Role	Female	25 Year(s)
Other Household 2	Mother's Partner	No Role	Male	26 Year(s)

LDSS Response

When conducting casework activity at a nearby residence, the TCDSS caseworker received information about the family, particularly regarding the fatal incident. Upon learning of the deaths of the children in their open Family Assessment Response case, TCDSS contacted the family and communicated extensively with the Missouri Department of Social Services. TCDSS learned pertinent information about the fatalities regarding investigations conducted by law enforcement, the fire departments, and the Federal Bureau of Alcohol, Tobacco and Firearms. TCDSS obtained records from the local fire department which noted detailed descriptions of their response, observations of the fire and home, symptoms of the persons involved (asphyxiation from smoke inhalation for the children), and cause of the ignition, which was described as "undetermined after investigation." There were smoke detectors in the home, but they did not work as they had no batteries.

TCDSS discussed the circumstances with the Missouri Department of Social Services and learned they declared the deaths to be, "not suspicious of abuse or neglect." It was relayed this decision was made after the autopsies and was determined by the Fire Marshal and Coroner. There was no open CPS or Preventive Services case in Missouri at the time of the fatalities.

The mother and three children had moved to Tompkins County in 2017. Shortly after their arrival, TCDSS became involved with the family. TCDSS assisted with interviews for consecutive CPS cases that were being investigated by the Missouri Department of Social Services. TCDSS later provided the mother and children an array of services when they became involved in their own open Family Assessment Response case. While involved with the family, TCDSS learned the children's father petitioned for custody; subsequently, the children were ordered to return to Missouri.

Prior to the deaths of the children, TCDSS linked the mother and her children to: domestic violence parent advocacy services, Early Intervention, Head Start, parenting classes, Family and Children's Services (a mental health counseling

service), the Child Development Counsel, and the Children with Special Needs Care Division through the Tompkins County Health Department. TCDSS agency staff and service providers involved were supportive to the mother throughout her involvement with Family Court in Missouri, and assistance was provided to advocate for her and assist her through the process. TCDSS became aware the mother was linked to a shelter and domestic violence services in Missouri upon her and the children's change in residency.

When TCDSS became aware of the fatal fire which took the lives of all three children, the mother was immediately contacted and offered condolences. TCDSS offered to find services in her area. TCDSS maintained contact with Missouri Department of Social Services and learned fatality-related services had been offered to all parents of the deceased children. The Missouri Department of Social Services informed in response to this incident, the free smoke detector program was restarted; and, when funds become available, there will be a free fire extinguisher and escape ladder program.

Official Manner and Cause of Death

Official Manner: Undetermined
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
Comments: There is no OCFS approved Child Fatality Review Team in Tompkins County.

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?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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:
DV services and housing and financial assistance were provided to the BM in her new state of residence. Grief services and monetary assistance for housing and funeral expenses were offered to the family. Other services were provided but not indicated above, as they were provided prior to the fatality.

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 surviving children.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
TCDSS spoke with CPS in Missouri about providing services as needed. Additionally, TCDSS asked BM if there was

any assistance they could provide. BM replied she was not in need of financial assistance and was already utilizing services in her state of residence. TCDSS learned services were offered to the BM, BF, and the father of the two other children who perished.

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?	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)	Status/Outcome	Compliance Issue(s)
02/28/2018	Sibling, Male, 4 Years	Mother, Female, 25 Years	Inadequate Guardianship	Far-Closed	No
	Deceased Child, Female, 2 Years	Mother, Female, 25 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 1 Years	Mother, Female, 25 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 4 Years	Mother's Partner, Male, 26 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report alleged on an unknown date, the 4-year-old sibling was misbehaving. The PS (mother's boyfriend) put soap in his mouth as a form of discipline. The roles of the child's BM, BF, the subject child, and her other sibling were unknown. A subsequent report was made against the BM on 3/12/18 alleging she allowed the PS, who was allegedly a registered level 3 child sex offender, to reside in the home with the children. The reports were consolidated and treated as one FAR case.

OCFS Review Results:
TCDSS adequately addressed the concerns in the report with the one child who was verbal, as well as the mother and her boyfriend. TCDSS effectively used FAR strategies to engage the family, elicit honesty, and learn what services the family felt they could benefit from. TCDSS then linked the family to an array of services and supported them when new concerns arose surrounding domestic violence between the children's mother and father. TCDSS continued their support upon learning of the deaths of the children during this open case, and appropriately gathered all necessary information.

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

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

There is no CPS history in New York State more than three years prior to the fatality.

Known CPS History Outside of NYS

The following CPS reports were investigated, closed, and unsubstantiated by the Missouri Department of Social Services. In 2 of these cases, TCDSS assisted with interviews of the BM and children.

On 3/5/15, there were concerns the BF beat the BM and the eldest child, and they left the home for safety. Regarding ongoing DV, it was noted BM's protective capacities appeared limited, and concerns were noted for BM's mental capacity and BF's parental capacity. The family denied the need for services and moved out of state.

On 10/17/17, it was alleged the BF hit the female child and left bruises, and acted in a manner that was physically and emotionally harmful to the children. TCDSS conducted interviews of the BM and children. The children had no injuries. The report was concluded on the basis that the children made no disclosures, the BF could not be contacted, the children resided out of state, and there was no evidence to substantiate the claims.

On 12/28/17, there were concerns the BF was a registered sex offender and may have sexually abused the subject child. It was also alleged the BF had beaten/injured the eldest child. TCDSS assisted with interviews of the children. Though it was noted the eldest child admitted the allegations were true regarding sexual acts/exploitation of himself and the subject child, the BF denied the allegations and it was said there was a "lack of competent or substantial evidence to indicate the case."

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