Office of Children and Family Services

Child Fatality Report

Report Identification Number: AL-20-026

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

Issue Date: Feb 18, 2021

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Clinton
Gender: Female
Date of Death: 08/10/2011
Initial Date OCFS Notified: 08/31/2020

Presenting Information

Clinton County Department of Social Services (CCDSS) received a report from the SCR on 8/31/20 alleging the parents had a history of abusing methamphetamine. On 8/10/11, there was a fire in the home that resulted from the parents cooking methamphetamine. The subject child, who was approximately 2-years-old at the time of the fire, did not make it out of the home. The child died as a result of the fire. There was a 4-month-old sibling living in the home at the time of the fire and the sibling made it out of the home safely.

Executive Summary

An SCR report was received on 8/31/20 regarding the death of the 2-year-old subject child that occurred on 8/10/11. The child died as a result of a fire at the family home. Additionally, concerns regarding the mother and father's substance abuse having an adverse effect on the surviving siblings was alleged. Since the child's death in 2011, the mother gave birth to a sibling. At the time of the death, there was a half-sibling residing in the home. The half-sibling, who was four months old at the time of the fire, made it out of the home safely. The half-sibling resided with her mother and had limited contact with the father.

Through interviews with collateral sources, it was learned there was a fire at the family home on 8/10/11. The mother, father, 2-year-old subject child, and then 4-month-old sibling were residing in the home at the time of the fire. The mother, father, and sibling safely got out of the home. The father attempted to go back into the home multiple times to save the subject child but was unable to access her room. The father suffered smoke inhalation and was hospitalized as a result.

CCDSS contacted law enforcement who agreed to assist with the investigation due to the parents' history of hostility towards CPS. Law enforcement assisted CCDSS with locating the family. The father had recently been released from prison and spoke with CCDSS via phone. The father had an extensive history of arrests and was incarcerated on drug related charges. The father refused to meet with CCDSS, stating the death happened more than nine years ago and he would not speak about it. The mother refused to meet with CCDSS. CCDSS assessed the safety of the sibling who was alive at the time of the fire. The half-sibling was observed safe in the care of her mother. The mother of the half-sibling reported the sibling had limited contact with the father. The father visited sporadically and visitation was supervised by a community-based agency.

An autopsy was conducted, and the cause of death was severe burns of the entire body including scalp and skull. The manner of death was accidental. There were no criminal charges in response to the fire or death. Law enforcement determined the fire was a tragic accident.

In response to the fatality, CCDSS unsubstantiated the allegations regarding the deceased child. CCDSS additionally unsubstantiated the allegations of inadequate guardianship and parent's drug/alcohol misuse against the mother and father for the surviving half-sibling and surviving sibling. There was no credible evidence the parents were abusing substances to the point of impairment while caring for the children. The surviving half-sibling was assessed throughout the investigation to be appropriately supervised and safe in the care of her mother. CCDSS was unable to observe and interview the sibling born after the death as the mother and father thwarted all efforts made by CCDSS. CCDSS exhausted efforts to locate and interview the family and enlisted the assistance of multiple government agencies including, several law enforcement agencies, the Supplemental Nutrition Assistance Program at CCDSS, and the medicaid unit at CCDSS. It was determined

the family moved out of the state, but CCDSS was unable to determine where the family moved as they used their benefits in multiple locations along the east coast. CCDSS completed all regulatory requirements.

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:
Casework was commensurate with case circumstances. Once all case objectives were met, CCDSS determined and closed the investigation.

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:
CCDSS exhausted efforts to locate and interview the family. Though the mother and father spoke with CCDSS via phone, neither would meet in person, claiming the death happened nearly 10 years prior and they did not wish to speak of the incident. CCDSS gathered sufficient evidence from collateral sources to determine 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: 08/10/2011 **Time of Death:** 07:30 AM

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

County where fatality incident occurred: Clinton
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? 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: Not impaired.

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	Female	22 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	21 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Month(s)

LDSS Response

CCDSS initiated their investigation within 24 hours of receipt of the report. They reviewed SCR history, spoke to the source, LE and DA's office, and met with collateral resources.

Through interviews conducted and medical records received, it was learned there was a fire at the family's home in the early morning hours of 8/10/11. The mother, father, subject child, and 4-month-old half sibling were in the home at the time the fire broke out. The mother, father, and half-sibling safely got out of the home, but the fire had engulfed the area of the home where the subject child was sleeping. The father made several attempts to enter the home in order to save the subject child but was unable to do so.

CCDSS worked diligently to locate the family. The mother and father were uncooperative, refusing to meet with CCDSS and LE. CCDSS was able to assess the safety of the surviving half-sibling, who resided with her mother. The half-sibling was assessed to be safe in the care of her mother. Medical records were received for the half-sibling and no concerns were listed for the child or the care provided to her. The mother of the half-sibling reported ongoing concerns for the mother and father and visitations between the father and half-sibling were restricted to supervised visitation with agency oversight.

CCDSS was unable to assess and interview the 5-year-old sibling who was born after the death. CCDSS exhausted efforts to locate the sibling and consulted their legal department regarding an access order to assess the sibling. It was determined CCDSS would not file in court for an access order but spoke with several collateral sources regarding the safety of the sibling. The collaterals who were contacted reported the sibling was safe in the care of her parents.

CCDSS accurately determined the investigation after conducting a thorough investigation. The safety and risk assessments were fitting to the case circumstances. CCDSS determined there was no credible evidence to support the allegations that the parents played a role in the subject child's death. Though the parents refused to cooperate with CCDSS, interviews with multiple collateral sources reflected no concern that the subject child's death was the result of abuse or neglect. CCDSS determined there was no credible evidence the parents were abusing substances while caring for the surviving siblings. Due to the family's refusal to cooperate, CCDSS was unable to provide the parents with community-based resources or offer additional services.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: Clinton County adhered to previously approved protocols for joint investigations by coordinating with law enforcement and contacting the DA's office.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
056232 - Deceased Child, Female, 22 Month(s)	056233 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
056232 - Deceased Child, Female, 22 Month(s)	056233 - Mother, Female, 21 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
056232 - Deceased Child, Female, 22 Month(s)	056233 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
056232 - Deceased Child, Female, 22 Month(s)	056238 - Father, Male, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
056232 - Deceased Child, Female, 22 Month(s)	056238 - Father, Male, 21 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
056232 - Deceased Child, Female, 22 Month(s)	056238 - Father, Male, 21 Year(s)	DOA / Fatality	Unsubstantiated
056235 - Sibling, Female, 4 Month(s)	056233 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
056235 - Sibling, Female, 4 Month(s)	056233 - Mother, Female, 21 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated

056235 - Sibling, Female, 4 Month(s)	056238 - Father, Male, 21 Year(s)	Inadequate Guardianship	Unsubstantiated
056235 - Sibling, Female, 4 Month(s)	056238 - Father, Male, 21 Year(s)	Parents Drug / Alcohol Misuse	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:

CCDSS contacted all relevant collateral sources regarding the death. CCDSS exhausted efforts to locate and interview the mother and father, but both refused to cooperate with investigative efforts; therefore the siblings were unable to be assessed.

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?	☐	☐	☒	☐

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 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: There was no removal of the surviving sibling following 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:
CCDSS attempted to locate, interview, and offer services to the family, but were unsuccessful. The family refused to cooperate and, though CCDSS consulted with their legal department, it was determined they could not file an access order in family court. CCDSS was unable to offer services, though the family has worked with services in the past related to grief and mental health counseling.

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:
Though the death occurred nearly 10 years ago, CCDSS attempted to provide resources to the family related to the death. The family was not compliant and refused to meet with CCDSS. In previous investigations, the family had received services from CCDSS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Though the death occurred nearly 10 years ago, CCDSS attempted to provide resources to the family related to the death. The family was not compliant and refused to meet with CCDSS. In previous investigations, the family had received services from CCDSS.

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)
06/05/2010	Deceased Child, Female, 7 Months	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Female, 7 Months	Father, Male, 20 Years	Inadequate Guardianship	Substantiated	

Report Summary:
CCDSS received a report from the SCR on 6/5/10 alleging on the same date at approximately 2:45PM, the father got violent and punched glass out of the vehicle windows.The mother and then 7-month-old subject child were in the vehicle at the time the father became violent. The father violated an existing order of protection during the incident.

Report Determination: Indicated **Date of Determination:** 08/02/2010

Basis for Determination:
CCDSS determined there was credible evidence that the subject child was placed at risk of harm due to her parents' actions. Though there was an existing order of protection, the mother violated the order of protection by allowing the father around the subject child and herself. The father was arrested for breaking the windows out of the vehicle.

OCFS Review Results:
CCDSS completed a thorough investigation into the allegations. Casework was completed within the required time frames and CCDSS exhausted efforts to locate and interview the father. Community-based referrals were offered to the family.

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

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

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

Known CPS History Outside of NYS

There was no known history outside of New York.

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