Child Fatality Report

Report Identification Number: SY-17-010

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

Issue Date: Sep 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	PS-Parent Sub
CH/CHN-Child/Children		
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-Cardiopulmonary 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-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

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Chenango
Gender: Male
Date of Death: 03/01/2017
Initial Date OCFS Notified: 03/22/2017

Presenting Information

On 3/22/17, an SCR report was received with the following concerns: On 2/28/17, the family's residence completely burned down due to a house fire. When LE responded, 16-year-old SC's body was found in his bed, burned and deceased. It was found SC died before the house caught fire. Therefore, SM and SF were held responsible for SC's death.

Executive Summary

This fatality report concerns the death of a 16-year-old male (SC) that occurred on 3/1/17. An initial SCR report was received on 3/22/17 with the allegations of IG and DOA/Fatality against SM and SF regarding SC. Chenango County Department of Social Services (CCDSS) conducted a thorough investigation surrounding SC's death. The official autopsy indicated the cause of death could not be determined, and LE ruled the death a homicide.

At the time of the fatality, SC resided with SM and SF; there were no SS or other children in the household. SC was deaf and had multiple health concerns and special needs. SM and SF recently adopted SC, and were previously his foster parents. In the early morning hours of 3/1/17, a structure fire engulfed the family's residence while SC remained inside the home; he was found deceased in his bed after the fire was extinguished. The home was unsalvageable, and although an autopsy was completed on SC, only a portion of his body was viable due to the severity of the burns. The autopsy did confirm there was an absence of soot in SC's airways, and an absence of any significant amount of carbon monoxide in the post-mortem blood, which indicated SC was already deceased at the time of the house fire. SM and SF reported neither were inside the home when the fire started; the cause of the fire was determined to have been from a wood stove, which was used to heat the home. At the time of the fire, SM was 20 miles away at a grocery store, reportedly to buy over the counter medication to help her sleep. SF was outside looking for their two dogs that reportedly ran off as he went outside to feed the farm animals. When EMS and first responders arrived, they noted SM and SF had strangely calm demeanors considering the circumstances. Neighbors that were interviewed reported the same. LE further indicated SM and SF's stories had inconsistencies throughout their interrogations. SM and SF were ultimately arrested and charged with 2nd Degree Murder, Arson, and Tampering with Evidence. SF remained incarcerated throughout the investigation and at the time of this writing; SM was released on bail, and the criminal investigation remained on-going.

At the time of SC's death, SM was 27 weeks pregnant. She gave birth to the newborn male SS on 6/30/17. A subsequent SCR report was made on that same date due to concerns surrounding the criminal charges pending against SM and SF, and their ability to appropriately care for the infant. SM reported she received regular prenatal care throughout her pregnancy, and the SS was born full term and healthy. While SM was still pregnant, CCDSS worked diligently with SM and friends with whom she resided to establish an appropriate supervision plan surrounding the safety of the SS; CCDSS consulted at length with their legal department, and it was determined there were insufficient grounds to file for a protective removal.

From the time the initial investigation began to the time of this writing, CCDSS met with SM, SF, and SS, assessed the home environment of SS, spoke with an abundance of collateral contacts, and offered the family appropriate services, which were accepted. The fatality investigation remained open at the time of this writing, and CCDSS continued to diligently monitor the safety and well-being of the SS.

Review of the family's history resulted in citations related to casework practices for CCDSS. In response, CCDSS 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) CCDSS has taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, CCDSS will review the plan(s) and revise as needed to further address ongoing concerns.

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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The investigation remained open at the time of this writing; however, casework was commensurate with the case circumstances and CCDSS gathered sufficient information surrounding the fatality.

Was the decision to close the case appropriate? N/A

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 investigation remained open at the time of this writing. SM agreed to engage in preventive services.

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

Child Fatality Report

Date of Death: 03/01/2017 **Time of Death:** 04:45 AM

Date of fatal incident, if different than date of death: 02/28/2017
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Chenango
Was 911 or local emergency number called? Yes
Time of Call: 01:00 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? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
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	Male	16 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)

LDSS Response

On 3/22/17, CCDSS received an SCR report regarding the death of SC, which occurred on 3/1/17. CCDSS initiated the investigation within 24 hours, and coordinated their efforts with LE and other members of their MDT. CCDSS determined there were no SS or other children in the household at the time of the fatality; however, SM was 27-weeks pregnant on the event date. A CPS history check was completed, and CCDSS promptly began reaching out to several collateral contacts to obtain more information about the family and the circumstances of SC's death.

CCDSS gathered accounts of the events surrounding the death of SC from SM, SF, first responders, LE, neighbors, and family members. CCDSS discovered SC was previously a foster child to SM and SF, and they recently adopted him. Both SM and SF were arrested for 2nd Degree Murder, Arson, and Tampering with Evidence following the autopsy results, which indicated SC had died prior to the house fire, and that the fire may have been intentionally set. CCDSS conducted a thorough interview with SF in jail, and attempted to interview SM; however, SM requested her lawyer be present and the interview was ended. CCDSS interviewed SM on a later date, after she was released on bail. Throughout the CPS investigation, SM and SF remained consistent with their stories that the house fire was started by their wood stove in the

early hours of the morning on 3/1/17, and neither SM or SF were in the home when the fire broke out; SM was at the store and SF was outside the home attempting to retrieve their two dogs that ran away. SF reported to CCDSS he saw the home was engulfed, and he ran to a neighbor's house to call 911. Emergency services and LE arrived on the scene, and were informed SC was unaccounted for. By the time emergency services could reach SC, the home was fully engulfed and SC was already deceased. An initial autopsy was performed on 3/2/17, and then again on 3/4/17; SC had to be identified via dental records. The autopsies and toxicology results determined the fire did not cause SC's death; however, an official cause of death could not be determined due to only a portion of SC's body being viable. The final autopsy report was obtained and noted the cause death as "Undetermined." LE has ruled SC's death a homicide.

A subsequent SCR report was received on 6/30/17 which noted concerns regarding SM giving birth to a newborn male SS on that same date, and SF and SM's pending criminal charges. SM resided with family friends at the time of SS's birth. CCDSS interviewed all household members and assessed the home environment for safety, finding no concerns. CCDSS worked diligently with SM to establish an approved safety plan which included SM being supervised at all times when with SS. CCDSS conducted several announced and unannounced home visits to ensure SM was abiding by the plan, was educated surrounding safe sleep, and had all necessary provisions for SS. CCDSS consulted with their legal department and discussed the case circumstances at length; it was determined a removal would be unsuccessful, and the safety plan was adequate since multiple appropriate adults would be supervising SM and SS. CCDSS offered SM preventive services, which she accepted. SF remained incarcerated at the time of this writing, and the court case against both parents was pending.

CCDSS completed all required assessments/reports for the investigations, consulted with numerous collateral contacts, including SC and SS pediatricians, emergency room/hospital staff, LE, ME, friends, and relatives.The fatality investigation remained opened at the time of this writing, and the safety plan surrounding the SS continued.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: This fatality investigation was conducted by the CCDSS MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: Chenango County does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
040143 - Deceased Child, Male, 16 Year(s)	040145 - Father, Male, 35 Year(s)	DOA / Fatality	Pending
040143 - Deceased Child, Male, 16 Year(s)	040145 - Father, Male, 35 Year(s)	Inadequate Guardianship	Pending
040143 - Deceased Child, Male, 16 Year(s)	040144 - Mother, Female, 33 Year(s)	DOA / Fatality	Pending
040143 - Deceased Child, Male, 16	040144 - Mother, Female, 33	Inadequate	Pending

Year(s)	Year(s)	Guardianship	

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 appropriate collaterals. A home visit to assess SC's environment could not be completed due to the severity of the house fire. The SS was born 3 months after SC's death, and that child's home was 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 safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Explain:
The RAP was not yet completed at the time of this writing.

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:
The SS was born three months after SC's death. SS was not removed as a result of this fatality report/investigation or for reasons unrelated to the fatality; however, CCDSS considered a removal and discussed this with their legal department. CCDSS' legal department determined a removal would not be successful.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 2

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Pending	SM, SF	Pending	Unknown
Comments:	SM and SF were charged with 2nd Degree Murder in the death of SC. SM was released on bail, and SF remained incarcerated at the time of this writing. Both are awaiting trial.		

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Preventive Services

Additional information, if necessary:
Preventive services were offered to SM after the birth of the SS, which she accepted. SM also engaged in grief counseling services after SC's death, and had several familial supports to assist her as needed. SF remained incarcerated throughout the investigation, and therefore it was unknown what services he was receiving, if any, in jail.

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:
Prior to his death, SC was engaged in a number of services via community-based agencies. After SS was born, a public health nurse began working with SM to ensure the SS's needs were being met.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Following SC's death, SM began to engage in grief counseling. After the birth of SS, SM obtained services from a Public Health Nurse to assist with the infant, and agreed to accept preventive services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	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)
05/15/2015	Deceased Child, Male, 14 Years	Father, Male, 33 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Male, 14 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unfounded	
	Deceased Child, Male, 14 Years	Father, Male, 33 Years	Lacerations / Bruises / Welts	Unfounded	

Report Summary:
Report received with concerns an 18 y/o UHM was physically assaulted in the home by SF while SC was present. Furthermore, it was alleged SM would not allow the UHM to call 911. The report also alleged SF had recently hit SC, causing a bruise/lump on SC's chin.

Determination: Unfounded | **Date of Determination:** 07/29/2015

Basis for Determination:
CCDSS completed their investigation and found an altercation took place between SF and UHM; however, SC, who was deaf, was in his bedroom, did not witness the incident, and was unharmed. SC reported to CCDSS he sustained bruising to his face after falling into a wooden shelf in his bedroom. The UHM had left the residence by the end of the investigation, and CCDSS determined SC was safe in the home.

OCFS Review Results:
Upon review, OCFS determined CCDSS did not attempt to speak with SC about discipline he received in the home. Appropriate collateral contacts were not made. CCDSS did not attempt to contact or interview the UHM regarding the incident.

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

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

Summary:
Although CCDSS did attempt to interview SC, they did not speak with him regarding discipline in the home.

Legal Reference:
432.1 (o)

Action:

CCDSS will fully explore the allegations in reports when interviewing subjects and individuals named.

Issue:
Overall Completeness and Adequacy of Investigation

Summary:
CCDSS did not interview, or make attempts to interview, the UHM who was mentioned in the report. CCDSS did not contact appropriate collaterals that could have provided further information regarding the safety and well-being of SC.

Legal Reference:
SSL 424(6); 18 NYCRR 432.2(b)(3)

Action:
CCDSS will interview, or make attempts to interview, all individuals named on a report. CCDSS will contact all appropriate collaterals relevant to allegations in the investigation.

[redacted]

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

9/26/13: Allegations of L/B/W and IG against SM and SF regarding SC; UNF.

Known CPS History Outside of NYS

There is no known CPS history for this family outside of NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

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