# Child Fatality Report

## Report Identification Number: BU-21-008

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

**Issue Date: Sep 03, 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
**Jurisdiction:** Erie
**Date of Death:** 01/18/2021
**Age:** 4 year(s)
**Gender:** Male
**Initial Date OCFS Notified:** 03/08/2021

### Presenting Information

Erie County Department of Social Services (ECDSS) received a report from the SCR alleging on 1/18/21, the biological father was under the influence of an unknown drug when he set the home on fire. The mother, the uncle, the subject child, and sibling were inside the home at the time of the fire. The children were sleeping in their bedroom together located at the back of the home. The mother and children were unable to get out of the home. As a result, both children and the mother passed away inside the home from smoke inhalation.

### Executive Summary

On 3/08/21, Erie County Department of Social Services (ECDSS) received an SCR report regarding the death of the 4 and 6-year-old children that occurred on 1/18/21. This report concerns the death of the 4-year-old child.

The father of the 6-year-old child was incarcerated out of state and had no contact with the child. ECDSS notified the father of the death. The record does not reflect any additional information was received from the 6-year-old's biological father.

The investigation revealed on the night of 1/18/21, the family home caught fire and the 4 and 6-year-old children and their mother perished in the fire. The deceased bodies were found in an upstairs bedroom.

An autopsy was performed and the final report stated the subject child and sibling died from smoke inhalation and thermal injuries, the manner was undetermined. The mother's autopsy was received and listed the cause of death as smoke inhalation, the manner also listed as undetermined. The mother's toxicology results were positive for hydrocodone, fentanyl, and norfentanyl. After diligent efforts made by ECDSS, it was unknown if she was prescribed these substances and if she was under the influence or impaired by these substances the night of the fire. A joint investigation was conducted with law enforcement with the assistance of a New York State fire investigator. At the time this report was written, evidence was still being processed and the exact cause of the fire had yet to be determined. There were no criminal charges filed and the law enforcement investigation was ongoing. The father gave varying information to law enforcement, some of which law enforcement did not find credible. Law enforcement suspected the father was under the influence of drugs at the time of the fire but no one at the scene had information that the father looked or acted impaired nor was he drug tested. Law enforcement did not have sufficient evidence to charge the father at the time the CPS investigation was closed.

The mother, father, and 4 and 6-year-old children resided with the paternal step-uncle at the time of their deaths. At the time of the fire, the father and step-uncle were present, but exited before flames engulfed the home. The step-uncle had been asleep in his bedroom on the second floor when he woke to smoke filling the room. The uncle was able to get out through the window. The mother and two children were in a bedroom down the hall and were unable to get out of the home. The father was already outside, pacing around the home. There were no additional children in the home.

The biological father was unable to be located following the fatal fire. ECDSS exhausted efforts to locate him by contacting multiple law enforcement agencies, social service agencies, calling relatives and collateral sources, and sending request for contact letters to all possible mailing addresses. ECDSS was unable to assess for the father’s service needs or interview him prior to closing the investigation.

ECDSS conducted a thorough investigation into the incident and contacted all necessary collaterals. ECDSS unsubstantiated the allegations as there was no credible evidence the fire started as a result of the father being impaired. Although there were inconsistencies in the father's account of the incident in his interview with law enforcement and the fire was labeled suspicious, the final lab results were not yet received, and the cause of the fire could not yet be determined. The case was closed as the father was unable to be located and there were no surviving siblings. Referrals for grief and mental health counseling were provided to the uncle, who was receptive to services.

## Findings Related to the CPS Investigation of the Fatality

**Safety Assessment:**

- **Was sufficient information gathered to make the decision recorded on the:**
    - **Safety assessment due at the time of determination?** 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

**Explain:**
Casework activity was commensurate with case circumstances. There were no other siblings or children residing in the home. The case was appropriately determined and closed once case objectives were met.

**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:**
Casework activity was commensurate with case circumstances.

### 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:** 01/18/2021 **Time of Death:** Unknown

**Time of fatal incident, if different than time of death:** 02:00 AM

**County where fatality incident occurred:** Erie
**Was 911 or local emergency number called?** Yes
**Time of Call:** 02:22 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?** Unable to determine

**Total number of deaths at incident event:**
**Children ages 0-18:** 2
**Adults:** 1

**Household Composition at time of Fatality**

| Household | Relationship | Role | Gender | Age |
|---|---|---|---|---|
| Deceased Child's Household | Aunt/Uncle | No Role | Male | 34 Year(s) |
| Deceased Child's Household | Deceased Child | Alleged Victim | Male | 4 Year(s) |
| Deceased Child's Household | Father | Alleged Perpetrator | Male | 29 Year(s) |
| Deceased Child's Household | Mother | No Role | Female | 28 Year(s) |
| Deceased Child's Household | Other Deceased Child - deceased sibling | Alleged Victim | Female | 6 Year(s) |

**LDSS Response**

Upon receipt of the SCR report on 3/8/21, ECDSS spoke to LE and learned a 911 call was received for a fire at 2:22 AM on 1/18/21. The mother, and two children ages 4 and 6 perished in the fire. There were no surviving siblings or other children in the home.

The step-uncle reported the family had been staying in his home for several months after falling on hard times and finding no other suitable housing arrangements. The uncle reported telling the father on 1/13/21 the family needed to find alternate housing. The uncle reported he woke around 2AM to the smell of smoke. He was able to get his window open and exited the home through the window. The uncle reported the father was already pacing around outside of the home. Neither he nor the father attempted to go back into the home, and both were aware the mother and two children remained in the home. The uncle reported he called 911 and at the time the fire department arrived, the home was fully engulfed in flames. The uncle denied knowing about drug use in the home, but had suspicions the father used drugs. The uncle reported no knowledge of the mother's substance abuse. The record did not reflect that the step-uncle had any knowledge of how the fire started. The uncle had children that were not present in the home at the time of the fire and resided with their mother. ECDSS provided referrals for community-based counseling services to the uncle, and he was receptive and engaged in services at the time the case was closed.

ECDSS made attempts to locate the biological father. It was learned the father was living a transient lifestyle following the

fire and attempts to contact him went unanswered. Law enforcement interviewed the father on two separate occasions and shared the results of those interviews with ECDSS. Law enforcement revealed the father provided inconsistent accounts of the events of the fire. Law enforcement stated three arson investigators went to the home and determined the fire was man-made but could not determine whether it was intentional or accidental. Evidence showed the fire started in the kitchen area. Law enforcement suspected the father was under the influence at the time of the fire and may have accidentally caused it while cooking. The record did not reflect why law enforcement suspected the father was under the influence at the time of the fire. The law enforcement investigation revealed the father had been involved in four other house fires. At the time the CPS investigation was closed, the law enforcement investigation remained open.

ECDSS determined and closed their investigation. The uncle was engaged in community-based mental health counseling at the time of case closure. ECDSS was unable to assess for the father's service needs.

## 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:** Medical Examiner

## Multidisciplinary Investigation/Review

**Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?** Yes
**Comments:** ECDSS adhered to previously approved protocols for joint investigation by coordinating with law enforcement and notifying the DA's office of the deaths.

**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 |
|---|---|---|---|
| 057861 - Deceased Child, Male, 4 Yrs | 057865 - Father, Male, 29 Year(s) | DOA / Fatality | Unsubstantiated |
| 057861 - Deceased Child, Male, 4 Yrs | 057865 - Father, Male, 29 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 057861 - Deceased Child, Male, 4 Yrs | 057865 - Father, Male, 29 Year(s) | Parents Drug / Alcohol Misuse | Unsubstantiated |
| 057862 - Other Deceased Child - deceased sibling, Female, 6 Year(s) | 057865 - Father, Male, 29 Year(s) | DOA / Fatality | Unsubstantiated |
| 057862 - Other Deceased Child - deceased sibling, Female, 6 Year(s) | 057865 - Father, Male, 29 Year(s) | Inadequate Guardianship | Unsubstantiated |
| 057862 - Other Deceased Child - deceased sibling, Female, 6 Year(s) | 057865 - Father, Male, 29 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:**
All relevant sources were contacted. ECDSS exhausted efforts to interview the father and assess for his service needs but were unable to locate him.

## 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:**
Though efforts to locate the father were exhausted, the father was unable to be interviewed or assessed for service needs. Referrals for counseling were offered to the uncle and he was engaged in services at the time of case closure.

**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 siblings or other children in the home.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** No
**Explain:**
Despite exhausting efforts to locate the father, ECDSS was unable to locate him and assess his need for services following the death.

## 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) |
|---|---|---|---|---|---|
| 09/12/2019 | Deceased Child, Male, 2 Years | Mother, Female, 27 Years | Inadequate Guardianship | Substantiated | Yes |

| | | | | |
|---|---|---|---|---|
| | Deceased Child, Male, 2 Years | Mother, Female, 27 Years | Lack of Supervision | Substantiated |
| | Deceased Child, Male, 2 Years | Aunt/Uncle, Female, 32 Years | Inadequate Guardianship | Substantiated |
| | Deceased Child, Male, 2 Years | Aunt/Uncle, Female, 32 Years | Lack of Supervision | Substantiated |

**Report Summary:**
ECDSS received a report from the SCR alleging on 9/12/19, the subject child left the home and wandered several houses away. The child had no shoes on and crossed a street where cars traveled. The child had developmental disabilities and required a higher level of supervision. The mother and maternal aunt knew the child required a higher level of supervision yet were unaware the child left the home.

**Report Determination:** Indicated | **Date of Determination:** 11/18/2019

**Basis for Determination:**
ECDSS determined there was credible evidence the mother and maternal aunt were not appropriate in providing adequate supervision for the child who required a higher level of care due to his developmental disabilities. The child was able to wander out of the home and remained outside for approximately 20-30 minutes. Law enforcement was called as a result.

**OCFS Review Results:**
ECDSS contacted collateral sources, notified all relevant adults of the report, and assessed the children residing in the home. The 7-day safety assessment was not completed and approved in CONNECTIONS until 11 days after receipt of the report.

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

**Issue:**
Timely/Adequate Seven Day Assessment

**Summary:**
The 7-day Safety Assessment was not documented and approved within the first 7 days. The Safety Assessment was not documented as completed and approved until 11 days after receipt of the report.

**Legal Reference:**
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

**Action:**
ECDSS will document and approve all safety assessments within the required timeframe.

## 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 State.

## 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

We appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality.

With respect to the required action related to the three-year prior CPS investigative history, we must unfortunately concur that ECDSS failed to complete and approve in Connections the 7 day safety assessment until 11 days after receipt of the report. These concerns are being addressed with the assistance and support of the Buffalo Regional Office of OCFS as relates to previous concerns whereby a related PIP has been consolidated. Additionally, during a scheduled Team Leader meeting conducted on August 17, 2021 a review and reminder of seven-day guidelines was discussed including the timely completion and submission of assessments

## 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