Child Fatality Report

Report Identification Number: SY-19-036

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

Issue Date: Nov 13, 2019

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 8 year(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 07/07/2019
Initial Date OCFS Notified: 07/07/2019

Presenting Information

An SCR report was received which alleged on 7/7/19, at approximately 1:48PM, a 911 call was made regarding an adult and 3 children unconscious in a car. The caller indicated the car had been there for up to two days and the windows of the car were taped shut. EMS arrived on the scene and discovered the adult female and 3 children approximate ages 10, 8, and 1 deceased in a vehicle. There was a pungent odor of decay indicating the adult and children had been dead for a few days. There appeared to be no injuries to the children and no obvious concerns regarding the condition of the vehicle.

Executive Summary

An SCR report was received on 7/7/19, regarding the deaths of 3 siblings and their mother that occurred on the same date. This report concerns the death of the 8-year-old male child. At the time of the death, the three children ages, 8, 7, and 3 were living with their mother. Onondaga County Department of Social Services (OCDSS) initiated an immediate investigation that included contact with the source and all other required contacts. SCR and criminal history checks were completed and reviewed; it was learned the mother had no previous history with CPS or LE. There was no known history of drug or alcohol misuse by the mother. There were no documented mental health concerns for the mother.

Through interviews, it was learned the mother did not have a stable support system. The maternal aunt was the mother's only support. She assisted the family financially and was a strong support until February 2019, when the mother told her she no longer needed her assistance. The maternal aunt moved out of the state and did not hear from the mother again. It was learned the three children were diagnosed with a condition that affected their cognitive functioning and all were receiving services for such. The father of the 8-year-old child never had a role in his life. No information was known about the father of the 7-year-old child.

It was presumed the children camped outside of the car because a tent was set up, and clean blankets and pillows were found in the car. Additionally, it was suspected the mother moved the children to the car once they fell asleep. The mother left a suicide note on the dashboard of the vehicle. A charcoal grill was found in the trunk of the car and the windows were taped shut. Due to the car being a rental car, the company could document when the doors of the car were last opened and shut. It was determined the door was last opened at 2:25AM on 7/5/19 and closed at 2:26AM on 7/5/19. Though the medical examiner determined all were deceased on the 5th, the date of death was recorded as 7/7/19 on the death certificates.

Syracuse Police Department investigated the deaths and found it to be a murder/suicide, with all parties being deceased. The autopsy was completed and listed the cause of death as carbon monoxide inhalation and the manner of death was homicide.

In response to the fatality, OCDSS accurately substantiated the allegations. OCDSS completed a thorough investigation, but due to there being no surviving children as well as the mother being deceased, not all resources could be explored. OCDSS provided the maternal aunt and father of the youngest child with a multitude of community based services. Additionally, OCDSS assisted with funeral expenses for the deceased children.

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:
OCDSS conducted a thorough investigation into the allegations. A safety assessment was not necessary at the time of case determination as there were no surviving siblings or other children in the home following the deaths.

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, and there was documentation of supervisory consultation throughout the case record.

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: 07/07/2019 **Time of Death:** 01:55 PM

Date of fatal incident, if different than date of death: 07/05/2019
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 01:48 PM
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: 3
Adults: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	7 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Other Household 1	Father	No Role	Male	38 Year(s)
Other Household 2	Father	No Role	Male	38 Year(s)

LDSS Response

On 7/7/19, OCDSS received an SCR report alleging DOA/Fatality against the mother for the 8, 7, and 3-year-old children. OCDSS coordinated with LE, reviewed the CPS history, and notified the DA's office about the death. Throughout the investigation, collateral contacts were made with the source of the report, personal collaterals for the family, medical personnel, and various service providers. There were no surviving children. The father of the eldest child was interviewed, but reported he did not have any contact with the child or his mother. He reported separating from the mother when she was pregnant and never being able to locate his son after that. He reported no concerns for the mother's mental health while they were together. The father of the youngest child was interviewed and reported inconsistent contact with the child, but reported seeing him on 7/4/19. The father reported he had no concerns for the mother at that time or any other time as the mother had not acted unusual. The father of the 7-year-old child was unknown at the time of this writing.

Through interviews with law enforcement, first responders, and the medical examiner, it was learned the mother locked herself and her three children inside the car she was renting, with a charcoal grill in the trunk. The mother and children ultimately succumbed to carbon monoxide inhalation because of the charcoal grill. Carbon Monoxide levels were tested at 524 parts per million with normal levels below 30. It was speculated the mother and children camped outside in a tent and, once the children fell asleep, she moved them into the car. The mother left a suicide note, which had not been released at the time of this writing. The car was a rental car and the company that owned the car sent a worker to collect the car as it was due back to the company. Upon arrival at the home, the worker noticed the deceased and immediately called 911. First Responders noted the bodies were already in the process of decomposition. Law Enforcement arrived on scene and declared it a crime scene.

Through interviews with family, it was learned the mother did not have a support system at the time of the deaths. The

mother had isolated herself by cutting off communication with her sister. Prior to February 2019, the maternal aunt was providing emotional and financial support to the family. It was in February that the mother decided she no longer wanted the maternal aunt in her life and asked her to move back to Virginia. The maternal aunt moved and had no further contact with the family. The maternal aunt did not have concerns for the mother's mental health, but reported the mother had a history of trauma dating back many years. The maternal aunt said the mother appeared mentally stable when she left for Virginia, but reported she was amid a custody battle with the father of the 3-year-old child.

OCDSS contacted the children's school and learned the eldest two each had an aide. The school principal said the mother was a strong advocate for her children and a model parent. The principal never had a concern for the mother or her care of the children.

In response to the fatality, OCDSS accurately determined the allegations after conducting a thorough investigation. OCDSS provided the maternal aunt and the fathers of the 3 and 8-year-old with a multitude of community based services, as well as funeral assistance.

Official Manner and Cause of Death

Official Manner: Homicide
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

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
051911 - Deceased Child, Male, 8 Year(s)	051914 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated
051911 - Deceased Child, Male, 8 Year(s)	051914 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
051912 - Deceased Child, Female, 7 Year(s)	051914 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
051912 - Deceased Child, Female, 7 Year(s)	051914 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated
051913 - Deceased Child, Male, 3 Year(s)	051914 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
051913 - Deceased Child, Male, 3 Year(s)	051914 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated

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:
The mother was the sole and primary caretaker for the children. She passed away at the same time as the children and was unable to be interviewed.

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: The father of the youngest child received referrals for bereavement counseling and assistance with funeral services.							

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 residing in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Following the deaths, the father of the youngest child received resources for mental health counseling, bereavement services, and funeral assistance.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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

There is no CPS investigative history in NYS within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

OCDSS appropriately reached out to North Carolina State Central Registry due to the mother and children residing there previously. There was no history in North Carolina for the family. There is 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