Child Fatality Report

Report Identification Number: NY-19-067

Prepared by: New York City Regional Office

Issue Date: Nov 04, 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: 3 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 06/10/2019
Initial Date OCFS Notified: 06/14/2019

Presenting Information

The 6/14/19 report alleged on 6/8/19, the SM and SC were in a building that caught on fire. The SM and SC were on the 16th floor. While exiting the building via the stairwell, the SM left the SC on the 14th floor. The SM continued down the stairs alone and exited the building. The SC was subsequently discovered by a passerby who brought her down the stairs and out of the building. The SC was transported by EMS to the hospital. As a result of the SM leaving the SC, the SC sustained burns to 85 percent of her body. On 6/10/19, the SC was pronounced deceased at 4:24 AM. The cause of death was acute respiratory syndrome which was the direct result of the SC's prolonged exposure to the fire.

Executive Summary

The 3-year-old female child (SC) died on 6/10/19. The autopsy listed the cause of death as complications of thermal injuries of 80 percent body surface area and the manner of death as accident (residential (apartment building) fire originating from common trash chute).

At the time of the SC's death, the family had an open investigation that began on 6/9/19. ACS was investigating the open report on 6/14/19 when the SCR registered a report that included the allegations of DOA/Fatality, IG, and B/S of the SC by the SM.

ACS learned that on 6/8/19, at about 1:00 AM, the SM and SC were visiting the maternal great aunt (MGA). The SM decided to stay the night due to the time and she did not want to travel with the SC that late. The SC's 17-yo and 10-yo cousins (the MGA's children) were in the home. The 17-yo cousin woke the SM and alerted her about a fire. The SM awoke and prepared herself and the SC to leave. The SM picked up the SC and carried her down the stairs. As she walked down the stairs, there was a large volume of smoke. The SM put the SC down as she became too heavy. The SM was going to pick her up again, but she could not locate her in the smoke. The SM continued down the steps to get outside, and alerted a firefighter that the SC was still inside the building. The SM learned that the SC got out of the fire and was transported to the hospital. The SC sustained burns to 85 percent of her body and died on 6/10/19. The SM denied drug and alcohol use.

On 6/26/19, the SM provided ACS with a copy of her clinical health appointment. The SM received care through a community based agency.

The ACS documentation reflected there were no SS or other surviving CHN in the SM's household. ACS provided grief counseling referrals to the BF, SM, maternal great aunt (MGA) and family members.

On 8/20/19, LE reported the investigation was pending video from the FD. LE awaited the findings from the District Attorney (DA) to make a decision on the case.

On 8/28/19, ACS Unsub the allegations of DOA/Fatality, IG, and B/S of the SC by the SM. ACS based the findings that showed the SM and SC were escaping a fire in a high-rise building located in the Bronx. The SM went down stairs of a 16-story building. She had the SC in her arms. The SM said she could no longer carry the SC as the smoke was heavy. The SM placed the SC on the steps, continued running out of the building and sought assistance. The SM and SC did not reside at the address of the fire. The SM escaped the fire and suffered from smoke inhalation. The SC sustained burns to

85 percent of her body. The SC died on 6/10/19. According to ME's preliminary findings, the immediate cause of death was complications of thermal injuries of 80 percent of body surface area and manner of death was accidental.

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?** 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

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:
There were no SS or other CHN in the SC's household.

Required Actions Related to the Fatality

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

Issue:	A 24-hour Fatality Report is required to be completed in CONNECTIONS within 24 hours of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 24-Hour Child Fatality Summary Report was not completed timely as it was not completed until 6/17/19.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Child Fatality Summary Report was not completed timely as it was not completed until 8/13/19.
Legal Reference:	CPS Program Manual, Chapter 6, K-2

Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	The ACS documentation did not reflect the agency interviewed the EMS/EMS Liaison, the MGGM, and Fire Marshal.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/10/2019 **Time of Death:** 04:28 AM

Date of fatal incident, if different than date of death: 06/08/2019
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
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? N/A
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: Unknown

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	3 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Other - maternal great grandmother	No Role	Female	69 Year(s)
Other Household 1	Father	No Role	Male	36 Year(s)

LDSS Response

On 6/17/19, ACS visited the MGM as the SM temporarily residing with the MGM due to the recent death of the SC. The SM informed ACS that she was not doing well, but coping. The MGM said she was scheduling an appointment with a mental health specialist for the SM.

On 6/18/19, ACS visited the home of the SM's aunt. ACS interviewed the SC's adult cousin who said she was not present when the incident occurred. This adult cousin reported she was also not present when the incident occurred; however, the SC's 17-yo female cousin informed her there was a fire in the building. She immediately returned to her apartment building but was unable to gain access to help her family. She said she left the SM and SC, and the 17-year-old and 10-year-old cousins in the home. The MGA said the SC and SM were visiting the home.

The 17-yo cousin said the incident occurred 1:00 AM. According to this cousin's account, at the time the incident occurred, she was alert and observed the 10-yo cousin while he played a game. The SM and SC were asleep. The 10-yo cousin told her he smelled smoke. She opened the door to the hallway and realized the hallway had smoke. She closed the door and alerted the SM. The SM started to put on her and the SC's belongings. They all exited the apartment; she went down first followed by the 10-yo and then the SM and SC. She believed everyone was behind her until she arrived downstairs and observed the SM without the SC. She asked the SM about the SC and the SM said they became separated.

On 6/21/19, ACS interviewed the personnel assigned to the SC's daycare. The daycare personnel said there were no concerns about the SC. The SM dropped her off and picked her up early. The SC was always dressed well and hardly missed daycare. The SM attended daycare events and was involved in the SC's life.

On 6/21/19, the MGM stated she was not present when the incident occurred. The MGM said the MGA informed her there was a fire in her building and there was a lot of smoke in the hallway. The SM, SC and the two cousins went downstairs and the SC became separated in the process.

On 7/1/19, ACS received medical information from the physician regarding the SC. The medical records reflected the SC had a pre-existing medical condition and took prescribed medication. The SM attended to the SC's health needs.

On 7/9/19, the BF said he no longer resided in Brooklyn due to the SC's death; he relocated to reside with a friend. The BF said he was interested in bereavement counseling.

On 8/16/19, the ME informed ACS that the autopsy was pending the results of FD/LE findings. However, preliminary results were consistent with a CH being in a fire. The death seemed accidental.

On 8/19/19, ACS conducted a home visit. The SM was seeking mental health treatment. The SM had a clinician and a therapist.

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: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No
Comments: The investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051547 - Deceased Child, Female, 3 Year(s)	051552 - Mother, Female, 29 Year(s)	DOA / Fatality	Unsubstantiated
051547 - Deceased Child, Female, 3 Year(s)	051552 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Unsubstantiated
051547 - Deceased Child, Female, 3 Year(s)	051552 - Mother, Female, 29 Year(s)	Burns / Scalding	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Other	☐	☒	☐	☐
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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The documentation did not reflect that ACS interviewed EMS/EMS Liaison, the MGGM, and Fire Marshal.

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 family was provided with community based referrals for grief 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? N/A
Explain:
There were no SS or other CHN in the SC's household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The family declined the offer for bereavement counseling.

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?	N/A
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)
06/09/2019	Deceased Child, Female, 3 Years	Mother, Female, 29 Years	Burns / Scalding	Unsubstantiated	Yes
	Deceased Child, Female, 3 Years	Mother, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The 6/9/19 report alleged on 6/8/19, there was a fire in the building where 3-yo SC and SM resided for the night. They were in the 16th floor apartment. During the fire, the SM tried to accompany the SC out of the building. However, on their way down, the SM left the SC sitting on the steps of the staircase and went down by herself. As a result of being left in a burning building the SC sustained burns to 80 percent of her body. She was in critical condition.

Report Determination: Unfounded **Date of Determination:** 08/09/2019

Basis for Determination:
ACS based the determination on the findings that showed the SM and SC were escaping a fire in a high-rise building. The SM went down the stairs of a 16-story building. The SM had the SC in her arms. The SM said she could no longer carry the SC as the smoke was heavy. She placed the SC on the steps and continued running out of the building reportedly to seek help. The SM and SC did not reside at the address where the fire occurred. The SM was able to escape the fire. She suffered from smoke inhalation. The SC sustained burns to 85 percent of her body. The SC died on 6/10/19 at about 4:24 AM at the hospital.

OCFS Review Results:
On 6/9/19, ACS interviewed medical personnel who said the SC sustained burns on 85 percent of her body and had respiratory failure. The SC did not breathe on her own and used a ventilator. The SC was not stable.

The SM said she did not reside in the building; she was visiting a cousin who resided on the 16th floor. They were asleep

when the fire broke out. She woke the SC and went down the stairs through the stair cases. The SM said she became overwhelmed by the smoke. She was not sure where she left the SC as the smoke was too much, and she had difficulty breathing or seeing anything. ACS interviewed the MGM, SM's aunt, BF, and the SM's cousins. On 6/10/19, the SC died.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The ACS documentation did not reflect the ME and Fire Marshal were interviewed regarding the SC's death.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

[redacted]

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

The SM was not known to the SCR or ACS more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

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