Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-028

Prepared by: New York City Regional Office

Issue Date: Sep 09, 2020

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 04/20/2014
Initial Date OCFS Notified: 03/12/2020

Presenting Information

The SCR report alleged approximately six years ago, two children were playing, while in the care of the PGF. The children gained access to matches and started a fire in the home. The PGF was able to get the children out of the home. While the PGF was trying to get others from the home, the children followed the PGF back into the home. The children died due to smoke inhalation.

The report also alleged the SF smoked marijuana in the home in the presence of the children. The six-year-old child suffered from nose bleeds due to asthma. The SF was aware that the smoke worsened the child's asthma but he continued to smoke in the home. The SF left marijuana in the home accessible to the children. The SF left the children home alone at nights for extended periods of time. The eight-year-old child was not mature enough to provide adequate supervision to the six-year-old for an extended period of time.

Executive Summary

ACS responded to the case address within the required timeframe and interviewed the father on the report. The alleged father confirmed there was a fire in 2014 that resulted in the death of his two-year-old niece and four-year old nephew. He explained that there were three children in the home at the time of the incident. The four-year-old had a twin sister who survived. He reported that his brother was the father of those children. For the purpose of this report, the alleged father will be referred to as the PU. According to the PU, the children were visiting the PGF who resided in the home. The children were playing with a lighter and the mattress caught on fire. The PGF took the children outside and returned inside to help the PGM. Two children followed the PGF back into the burning home and were overcome by smoke. The FDNY found them unresponsive; they did not survive. The PU reported that at that time he was not in New York.

The PU was the father of the two surviving children. The PU reported that his children resided with their mother at a different location; however, they visited him three times per week. He stated he and their mother work to provide all basics for their children. He admitted he smoked marijuana often but never in the presence of the children. He explained he did not leave the children home alone because he received assistance from the PGF or the PA who resided in the home. The PU repeatedly reported the PGF was too sick and could not be interviewed.

The father of the deceased children admitted via telephone that the SS was in his care under a private arrangement between he and the SS's mother. The father refused the ACS Specialist access to the home and he declined an interview.

On 3/13/20, the Specialist interviewed the SS at school, and she gave details of the incident similar to that of the PU. She confirmed she resided with her mother until she transferred to a new school. The Specialist visited the six-and nine-year-old children at their school and the staff reported no concerns regarding their academic progress or behavior.

The ACS Investigative Consultant requested information from the office of the ME. The ME ruled the cause of death was smoke inhalation and the manner an accident (house fire originating in bedding).

ACS divulged the identity of the source of the report in the safety assessment.

ACS unsubstantiated all the allegations of the report.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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 investigation reflected that the PU was named in the report as the subject; however he was not in NY at the time of the incident and he was not a Person Legally Responsible for the children who were at the home on the day the incident occurred.

Required Actions Related to the Fatality

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

Issue:	Confidentiality of reporters
Summary:	ACS divulged the identity of the source in three of the Safety Assessments.
Legal Reference:	SSL 422(4)(A); 05-OCFS-ADM-02
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation 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

Child Fatality Report

Incident Information

Date of Death: 04/20/2014 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 01:00 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☒ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Mother	No Role	Female	34 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Male	36 Year(s)
Other Household 1	Other Child - cousin	Alleged Victim	Female	8 Year(s)
Other Household 1	Other Child - cousin	Alleged Victim	Male	6 Year(s)
Other Household 2	Grandparent	No Role	Male	63 Year(s)
Other Household 3	Other Child - half-brother	Alleged Victim	Male	1 Year(s)
Other Household 3	Other Child - half-sister	Alleged Victim	Female	4 Year(s)
Other Household 3	Other Deceased Child - half-brother	Alleged Victim	Male	4 Year(s)

LDSS Response

On 3/12/20, ACS initiated the investigation by visiting the case address and interviewing the alleged subject father who stated he was not the father of the children on the report; he was the PU; his brother was the children's father. The PU

reported he was not a person legally responsible for any of the children in the report. The PU explained that in 2014, the PGF's grandchildren (ages 4, 4, and 2) were visiting and they were in the care of the PGF. A fire started in the home and the PGF took all the children out and helped the PGM escape. The fire fighters found the two children (ages 4 and 2) in the home and they had succumbed to smoke inhalation. The PU reported that he had been living in another state and was not in NY at the time of the incident.

Regarding the current allegations of the report, the PU denied his children lived with him and he said they visited him approximately three times per week. He and their mother co-parent to provide the children with their basic needs. The children were assessed as safe and the home presented no hazards. The PU explained that the PGF and the PA resided in the home and he never left the children unattended. The PU reported he was involved in a domestic incident that occurred in the home when the children were not there; he filed a police report for damages. The PU admitted he smoked marijuana but not in the presence of the children. ACS noted there were no hazardous conditions in the home, and the PU reported no mental health conditions. The PU reported that the PGF had a pre-existing medical condition and was unable to be interviewed.

The Specialist attempted to visit the father on 3/12/20 and no one answered the door; however, the father answered the phone and reported that the ten-year-old twin SS of the deceased four-year-old and half-sister of the two-year-old was in his care temporarily, following a private agreement with the child's mother. The BF explained that the SS was asleep, and he did not allow ACS to enter the home. The father declined an interview.

On 3/13/20, the Specialist visited the school and interviewed the SS who provided details of the incident. She stated that she, her brother and half-sister were in the basement with the PGF who had fallen asleep on the bed. While they were watching television, they saw smoke coming from the bed and they woke the PGF who took them outside across the street. The PGF returned to the home to help the PGM escape; however, the others followed the PGF into the house. The case documentation reflected the SS received services to address the trauma she experienced as a result of the incident. The SS denied being left home alone or that anyone in the family smoked. The school staff referred the SS to a weekend program where she could make friends; she exhibited signs of attention seeking.

The Specialist visited the school and interviewed the PU's children, separately, and they confirmed the information given by the PU. The children reported they know about drugs and alcohol and they had never seen any family smoke or drink. They also stated they were never left alone and the PGF would take them with him. The staff reported the children were on target academically with no concerns for their safety. The Specialist left messages for the children's mother to contact ACS to no avail.

On 3/20/20, the ME confirmed the cause of death was smoke inhalation and the manner accidental (house fire originating in bedding).

ACS unsubstantiated all the allegations of the report.

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 death of two children occurred six years ago; at the time of the incident, there was no SCR report.

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
054676 - Deceased Child, Female, 2 Yrs	054682 - Aunt/Uncle, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
054676 - Deceased Child, Female, 2 Yrs	054682 - Aunt/Uncle, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
054676 - Deceased Child, Female, 2 Yrs	054682 - Aunt/Uncle, Male, 36 Year(s)	Lack of Supervision	Unsubstantiated
054783 - Other Deceased Child - half-brother, Male, 4 Year(s)	054682 - Aunt/Uncle, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
054783 - Other Deceased Child - half-brother, Male, 4 Year(s)	054682 - Aunt/Uncle, Male, 36 Year(s)	Lack of Supervision	Unsubstantiated
054784 - Other Child - half-sister, Female, 4 Year(s)	054682 - Aunt/Uncle, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
054918 - Other Child - cousin, Female, 8 Year(s)	054682 - Aunt/Uncle, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
054919 - Other Child - cousin, Male, 6 Year(s)	054682 - Aunt/Uncle, Male, 36 Year(s)	Inadequate Guardianship	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?	☐	☐	☒	☐
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 PGF was not interviewed; his son reported he was not available due to a medical condition.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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

Fatality Risk Assessment / Risk Assessment Profile

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

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐

Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
There was no CPS investigation at the time of the death of the children. Therefore no services were offered or provided.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
There was no CPS investigation at the time of the death of the children.

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

On 3/9/16, the SCR registered a report that alleged approximately two months prior, the PU and his 12-year-old male child moved to NY and the PU did not enroll the child in school. On 3/21/16, two additional reports were registered that alleged the PU was advised to return the SC to his mother who resided in another state; however, the SC was still in the home. The PU was aware the SC smoked marijuana on the porch of the home and did not address the issue.

ACS unsubstantiated the allegations of Educational Neglect, CD/AM and IG. ACS was unable to confirm whether the child on the report was the PU's child as he did not disclose the name of his children. The PU stated the male child was not related to him and that he lived in another state with his mother.

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