Child Fatality Report

Report Identification Number: NY-23-046

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

Issue Date: Nov 02, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 13 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 05/11/2023
Initial Date OCFS Notified: 05/11/2023

Presenting Information

The New York City Administration for Children's Services (ACS) received an SCR report on 5/11/2023, which alleged at approximately 2:00 AM on 5/9/2023, the father (SF) was engaged in an illegal activity when the house caught fire. The mother (BM), adult sibling (AS), 13-year-old subject child (SC), and 9 and 8-year-old siblings were asleep at the time of the fire. The 13-year-old subject child and minor siblings were transported to the hospital with significant burns. The mother and adult sibling were pronounced dead. The 13-year-old child was pronounced dead on 5/11/2023 due to an anoxic brain injury. The 9-year-old sibling was pronounced dead on 5/10/2023 and the 8-year-old sibling remained hospitalized with a positive prognosis. It was believed the father's illegal activity contributed to the house fire.

Executive Summary

This report concerns the death of a 13-year-old child which occurred after sustaining injuries in a house fire. The mother, 13-year-old child, adult sibling, and two minor siblings were asleep on the third floor of the home when, at approximately 2:15 AM, the fire began. The father was cooking oil in the kitchen on the second floor of the building. The oil ignited and the father attempted to put the fire out with a pillow, spreading the fire. The father then attempted to bring the ignited pot outside of the home, spilling it in the stairwell and causing the fire to spread more.

A neighbor called 911 and police and the fire department responded to the scene. The father was outside of the home and suffered burns to his arms and upper chest. The mother, adult sibling, 13-year-old child, and the two minor siblings were pulled from the home by the fire department. The mother was pronounced dead on scene. The adult sibling, 13-year-old child, and minor siblings were transported to the hospital where the adult sibling was pronounced dead upon arrival. The 13-year-old child and minor siblings were admitted and treated for their injuries. The 13-year-old child was pronounced dead on 5/10/2023, due to an anoxic brain injury. The 9-year-old sibling was pronounced dead on 5/11/2023, suffering burns to 50% of her body and cardiac arrest. The 8-year-old sibling suffered burns to 26% of his body, was expected to survive, and was discharged to family members a few days later. The father underwent multiple surgeries and remained hospitalized for a month. The father made appropriate plans for the care of the 8-year-old sibling throughout the investigation.

ACS interviewed law enforcement and the fire department investigator. The fire investigator stated an accelerant was present. The criminal investigation was pending and exact cause of the fire was under investigation at the time ACS closed their investigation, though the preliminary investigation determined the father potentially started the fire accidentally while illegally making oil to put into vape pens to sell in their family-owned store.

ACS unsubstantiated all allegations against the father regarding the death of the 13-year-old child, and injuries sustained by the other children in the house fire. ACS determined that without a definitive cause and intent, a substantiated finding could not be made, despite stating in the Risk Assessment Profile the child died due to abuse and stated the father's actions started the fire and caused it to spread further. Services were offered in relation to the death of the child to support the father and 8-year-old sibling and were accepted.

PIP Requirement

ACS will submit a PIP to the New York Regional Office within 30 days of receipt of this report. The PIP will identify action(s) ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS

will review the plan and revise as needed to 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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** No

Explain:
Evidence gathered during the investigation supported a substantiated determination of DOA, II, B/S and IG allegations despite lacking pending information on the exact cause of the fire.

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:
There was detailed documentation in the case record of supervisory consult throughout the investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Allegations of DOA, IG, and II were unsubstantiated despite meeting the requirements of a preponderance of the evidence to support the allegations be substantiated. The SF started the fire in the home leading to the death of the SC, SS, AS, and BM.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual and/or consult with the New York Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/11/2023 **Time of Death:** 12:57 PM

Date of fatal incident, if different than date of death: 05/09/2023
Time of fatal incident, if different than time of death: 02:00 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 02:15 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

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

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Adult Sibling	No Role	Female	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	13 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Mother	No Role	Female	35 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	9 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Year(s)

LDSS Response

ACS received an initial report regarding the fatal incident on 5/9/2023 and initiated their investigation. ACS coordinated their response with LE and fire department investigators. Interviews of the surviving family members were not able to be conducted immediately following the incident due to their critical conditions and subsequent medical treatments.

ACS interviewed LE and fire department investigators upon receipt of the SCR report. The SF informed LE and the fire department he had been cooking oil in the home when the fire started. The SF attempted to put the fire out with a pillow,

then attempted to bring the pot of oil outside the apartment, causing the fire to spread as he had spilled some. The fire department investigator stated an accelerant was present and near where the SF was cooking the oil. The SF was then medically incapacitated and hospitalized. The BM, AS, and 3 minor children were recovered from the home. The BM and AS were pronounced dead upon their recovery and the 3 minor children were transported by ambulance to the hospital.

ACS spoke to hospital staff treating the SC and 9-year-old SS. The 9-year-old sibling was pronounced dead on 5/10/2023 at 6:50 AM. The SC suffered burns to approximately 50% of her body and was presumed brain dead. The 13-year-old SS was removed from life support and pronounced dead on 5/11/2023 at 12:57 PM due to an anoxic brain injury.

The 8-year-old SS was hospitalized in a separate hospital. The medical providers informed ACS he was expected to live and was in stable condition immediately following the incident. The SS was interviewed in the hospital and expressed only knowing the family was involved in a house fire. The SS stated the BM and children were sleeping on the third floor of the building and did not recall further details.

The SF was interviewed in the hospital when he was stable and alert. The SF did not disclose details of the fire to ACS, citing the ongoing LE investigation, and made an appropriate plan for the care of the 8-year-old SS by family members. The SF remained hospitalized for over a month. Upon his discharge, the SF moved in with family to assist in the care of the 8-year-old SS during his continued recovery. Services were offered in relation to the fatal incident and accepted.

ACS interviewed LE and the fire department investigator. The fire department investigator informed ACS it appeared the fire started when the SF was cooking oil to put into vape pens to sell in the family's store and an accelerant was present. The SF attempted to put out the fire, though caused it to spread. The SF attempted to bring the pot of oil outside the home, spilling some in the stairwell. The final report on the cause of the fire was not available and the LE investigation was ongoing at the time ACS closed their investigation.

ACS unsubstantiated all allegations against the SF regarding the death of the SC and injuries sustained by the other children in the house fire. Investigations into the definitive origin of the fire and potential criminal activity by the SF were ongoing at the time ACS closed their investigation. ACS determined that without further information regarding the origin and intent of the fire, the allegations regarding the SF's actions to start and spread the fire inside the home could not be substantiated. ACS' determination was not accurate as the investigation revealed a preponderance of evidence that the father's actions placed the children at imminent risk of serious harm.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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 referred to an OCFS approved Child Fatality Review Team? No
Comments: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

065008 - Deceased Child, Female, 13 Yrs	065010 - Father, Male, 38 Year(s)	DOA / Fatality	Unsubstantiated
065008 - Deceased Child, Female, 13 Yrs	065010 - Father, Male, 38 Year(s)	Burns / Scalding	Unsubstantiated
065008 - Deceased Child, Female, 13 Yrs	065010 - Father, Male, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
065008 - Deceased Child, Female, 13 Yrs	065010 - Father, Male, 38 Year(s)	Internal Injuries	Unsubstantiated
065012 - Sibling, Female, 9 Year(s)	065010 - Father, Male, 38 Year(s)	DOA / Fatality	Unsubstantiated
065012 - Sibling, Female, 9 Year(s)	065010 - Father, Male, 38 Year(s)	Burns / Scalding	Unsubstantiated
065012 - Sibling, Female, 9 Year(s)	065010 - Father, Male, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
065013 - Sibling, Male, 8 Year(s)	065010 - Father, Male, 38 Year(s)	Burns / Scalding	Unsubstantiated
065013 - Sibling, Male, 8 Year(s)	065010 - Father, Male, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
065013 - Sibling, Male, 8 Year(s)	065010 - Father, Male, 38 Year(s)	Internal Injuries	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?	☒	☐	☐	☐

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	☒	☐	☐	☐
Explain: Risk was assessed throughout the investigation and appropriate services in relation to the death of the SC were offered and accepted by the family.				

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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? Yes
Explain:
Services were offered on behalf of the SS and accepted by the SF.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Services were offered in relation to the death of the SC and accepted by the SF.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)
11/18/2022	Sibling, Female, 9 Years	Father, Male, 37 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
The SCR report alleged the SF became angry and physically aggressive towards the 9-year-old SS. The SF allegedly hit the 9-year-old SS on the hand with a phone charger, leaving a red mark on her hand.

Report Determination: Unfounded **Date of Determination:** 12/30/2022

Basis for Determination:
ACS received the SCR report and interviewed all family members and obtained information from relevant collateral sources. The SF and 9-year-old SS both disclosed the physical incident had occurred, though no mark or bruise was left. The 9-year-old SS was observed by ACS to have red marker on her hand and it was washed off. The SF agreed to stop using physical discipline as a punishment and the investigation was closed.

OCFS Review Results:
ACS conducted an investigation which met regulatory requirements and a determination of the allegation was made in congruence with the evidence gathered.

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

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 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