Child Fatality Report

Report Identification Number: SY-22-048

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

Issue Date: Apr 24, 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: 5 year(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 10/27/2022
Initial Date OCFS Notified: 10/27/2022

Presenting Information

On 10/27/22, the father picked up the subject child from school and dropped him off at the child's home, where he lived with his mother. The father did not ensure that anyone was home prior to leaving the child inside the home unattended. Just before 4:00PM, while the subject child was unattended in the home, the home caught fire. It was unknown exactly when or how the home caught fire. A bystander was able to pull the child from the burning home; however, the child was badly burned and unconscious. The child was transported to the hospital and pronounced deceased at 4:16PM. The mother and siblings had unknown roles. A second SCR report was received 10/28/22 regarding the fatality.

Executive Summary

This fatality report concerns the death of the 5-year-old male subject child. Onondaga County Department of Children and Family Services (OCDCFS) received two SCR reports regarding the child's death on 10/27/22 and 10/28/22. At the time of the subject child's death, he resided with his mother and siblings, ages 19 years, 15 years, 3 years, and 10 months.

On 10/27/22, the subject father had walked the subject child home from school and brought him to the mother's house, where the subject child resided. The father walked the child inside the house and spent a couple minutes with him prior to leaving. The father thought the 19-year-old sibling was home, as that was the family's arrangement on Thursdays since the mother worked and would not be home. The father was unaware that the 19-year-old sibling had left earlier in the day and as a result, the subject child was left home alone. Shortly after the father left the home, the home caught fire. The subject child was removed from the home by a neighbor and the fire department responded. Life-saving efforts were taken over by emergency medical services and the child was transported via ambulance to the hospital, where he was pronounced dead at 4:16PM.

The medical examiner was notified and performed an autopsy. The cause of death was inhalation of products of combustion and the manner of death was accidental. Law enforcement investigated and at the time this fatality report was written, no criminal charges had been brought and the investigation remained ongoing.

OCDCFS made several home visits and interviewed the mother, 19 and 15-year-old siblings, and relevant collaterals. OCDCFS was initially asked by law enforcement not to speak with the subject father; however, was permitted to speak with him regarding the fatal event as the investigation progressed. All siblings were assessed to be safe and remained in the care of the mother throughout the CPS investigation.

The CPS investigation remained ongoing at the time this report was written. The mother was offered bereavement services, burial assistance, and financial assistance which was used to help replace items lost in the fire.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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:
The CPS investigation remained ongoing at the time this fatality report was written, therefore the closing safety assessment, RAP, and determination had not yet been completed.

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: 10/27/2022 **Time of Death:** 04:16 PM

Time of fatal incident, if different than time of death: 03:24 PM

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 03:29 PM
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: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	5 Year(s)
Deceased Child's Household	Mother	No Role	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Male	19 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Month(s)
Other Household 1	Other Adult - 15yo SS's Father	No Role	Male	58 Year(s)
Other Household 2	Father	Alleged Perpetrator	Male	34 Year(s)

LDSS Response

OCDCFS initiated their investigation within 24 hours and coordinated their efforts with LE. OCDCFS contacted the sources of both reports, completed a CPS history check regarding the family, and informed the DA of the fatality. The safety of the surviving siblings was assessed on 10/27/22 and an initial home visit occurred on the same date.

OCDCFS interviewed the parents regarding the events leading up to the SC's death. On 10/27/22, the SF picked up the SC from school and walked him home to the BM's house. The SF walked the SC inside, stayed with him for a few minutes, gave him the television remotes, then left. The SF assumed the 19yo SS was home because that was the usual arrangement. The 19yo SS's bedroom door was closed at the time; however, that was typical. The SF and 19yo SS did not usually communicate during the SC transitioning from the SF to the SS's care. On the walk home, the SF had exchanged text messages with the BM and the BM did not say the 19yo SS was not home. The SF believed the 19yo SS was home when he left the BM's house. The SF denied seeing any candles, incense, matches or lighters present. He had not cooked or smoked anything while in the home. The SF did not believe the SC would have tried to play with fire. The SF shared he had been told the fire originated in the living room.

The BM was not home for the fatal event but was asked to describe what she knew regarding the incident. The BM stated the SF walked the SC home from school, as he normally did. The BM talked with the SC around 2:45PM and the SC told her he was home, and the SF was there. Around 3:15PM, the BM received phone calls from people telling her that the house was on fire. The BM was unaware who was home at that time. The SF usually left the SC with the 19yo SS; however, on that day, the BM's sister had picked up the 19yo SS to run errands. The BM denied the SC would have used the stove or done anything that would have caused a fire and denied the SC had ever been left home alone before.

OCDCFS interviewed the 19 and 15yo SSs. The 19yo SS corroborated that he had been with his aunt at the time of the fire. The 19yo SS stated that the SF did not usually check to see if he was home prior to leaving the SC with him. The

15yo SS was at a job interview at the time the fire broke out and the 3yo and 10-month-old SSs were at daycare.

Collateral contact with the fire department confirmed no one else was in the home. When the fire department arrived, the SC had already been brought out of the house. The fire department said they were told the SF came back to the house after the ambulance left; however, he was not on the scene upon their arrival and did not present to the hospital. The fire department had attempted to speak with the SF but he was unwilling at the time. Video was recovered from a neighboring residence and showed the 19yo SS left the home before the SF arrived with the SC. The camera then showed the SF leaving the home at 3:10PM. No one else came or went until flames were seen engulfing the front of the residence. At the time OCDCFS spoke with the fire department, the cause of the fire was unknown.

OCDCFS reviewed hospital records which indicated the SC was pulled out of the house by neighbors. CPR was started at the scene and emergency medical technicians took over life-saving efforts upon arrival. The SC was transported to the hospital. Between the ambulance and hospital, the SC received nine rounds of CPR and nine rounds of epinephrine had been administered with no results.

At the time this fatality report was written, the CPS investigation remained ongoing, therefore, no determination had been made regarding the allegations against the father.

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)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062992 - Deceased Child, Male, 5 Yrs	062999 - Father, Male, 34 Year(s)	DOA / Fatality	Pending
062992 - Deceased Child, Male, 5 Yrs	062999 - Father, Male, 34 Year(s)	Burns / Scalding	Pending
062992 - Deceased Child, Male, 5 Yrs	062999 - Father, Male, 34 Year(s)	Inadequate Guardianship	Pending
062992 - Deceased Child, Male, 5 Yrs	062999 - Father, Male, 34 Year(s)	Lack of Supervision	Pending

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?	☐	☒	☐	☐
School	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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:
Records from the treating hospital were received and reviewed.

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:
It was learned on 10/31/22 that there was an Order of Protection between the mother and father; however, the record did not reflect further follow-up regarding the contents of the Order of Protection until 2/28/23. The case record did not contain details of the Order and whether or not the Order stipulated no contact with the children.

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:
The mother was provided information on bereavement resources. It was unknown if any of the surviving siblings utilized services. The record did not identify any specific service needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was provided with information on bereavement services and burial assistance, although it was unknown if either service was utilized. The family received financial help from the Red Cross in response to the fire. OCDCFS assisted the family in replacing household items when they moved into their new apartment. The record did not reflect if the father was offered information on bereavement services.

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

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

In 2018, OCDCFS substantiated allegations of Inadequate Guardianship against the subject father, in regards to the subject

child. The father was not cooperative with the investigation and did not participate in an interview with OCDCFS. OCDCFS concluded there was credible evidence to support that the father perpetrated domestic violence against the mother. An Order of Protection was sought, but charges were not filed. It was believed at case closing that the father relocated out of state.

In 2010, OCDCFS was involved with the family for multiple investigations and substantiated allegations of Inadequate Guardianship, Lack of Supervision, and Parent's Drug Alcohol Misuse against the mother. A services case was opened as a result. There were concerns about a pattern of domestic violence, which had escalated to involve law enforcement. The mother had a pattern of unstable housing and drug use. At case closing, the Court had awarded custody of the 15-year-old to his father, as well as the temporary residency of the 19-year-old.

In 2008, OCDCFS substantiated the allegation of Inadequate Guardianship against the mother, regarding the 19 and 15-year-old sibling. The mother had allowed unsupervised contact between the children and the 15-year-old sibling's father, who she knew had been charged with Endangering the Welfare of a Child. At case closing the mother agreed to not allow unsupervised contact.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

Preventive services were provided in 2010 to the mother and 19-year-old sibling, age 6 at the time. A family services stage was opened 2/4/10, with goals focused on obtaining stable housing, enrolling in health insurance, and for both the mother and sibling to engage in mental health counseling. Additional concerns arose regarding substance misuse by the mother. The services case was closed in October 2010, with little to no progress being made. The mother failed to follow through with the service plan, despite frequent reminders of appointments and availability of resources. At the time the case was closed, the sibling was residing with a half-sibling's parent, who was granted temporary custody during a family court appearance the mother did not attend. No other children resided in the home at the time the family services stage closed.

Additionally, preventive services were initiated in 2005 for the mother and 19-year-old sibling, age 2 at the time, regarding concerns of substance misuse by the mother and parenting skills; however, the mother declined preventive services and the referral was closed without further intervention.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Other - Criminal Contempt		**Degree:** 2	
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
09/22/2022	Subject Father	Pending	Unknown
Comments:	The father was arrested 9/22/22 for violating an Order of Protection. The record did not indicate when the Order of Protection was established. It was learned there was an Order of Protection between the mother and father. Court was ongoing and the next court date was 4/13/23.		

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