Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-21-024

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

Issue Date: Dec 13, 2021

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: 14 year(s)
Jurisdiction: Allegany
Gender: Male
Date of Death: 07/15/2021
Initial Date OCFS Notified: 07/15/2021

Presenting Information

On 7/13/21, the father and the 14-year-old male subject child were burning scraped wood and brush in the backyard. The child gained access to a can of acetone and threw it into the fire, causing an explosion. The child's clothes and body caught on fire. The father grabbed the child, placed him in the pool and then drove the child to the hospital where he was intubated. As a result of the explosion, the child sustained burns to 50% of his body. On 7/15/21, as a result of the injuries, the child went into cardiac arrest and subsequently passed away. The child passed away during an open investigation regarding the fatal incident.

Executive Summary

An SCR report received on 7/14/21 alleged the 14-year-old subject child with concerns the father was not properly supervising the child when the child put a can of acetone into a fire in the family's yard. As a result, there was an explosion and the child was badly burned. Due to the explosion and the child's injuries, the child was transported to the hospital and was on a ventilator. On 7/15/21, subsequent SCR reports were received concerning the child's death after he succumbed to his injuries. At the time of his death, the child resided with the father and siblings, aged 10 and 16 years. The mother resided out-of-state and had other children who were in Foster Care. The siblings were assessed to be safe with their caregivers.

Allegany County Department of Social Services (ACDSS) coordinated investigative efforts with law enforcement upon receipt of the initial report. Law enforcement found no criminality during their investigation and closed their case without charges. An autopsy was performed, and the cause of death was complications of multiple thermal injuries and the manner of death was accidental.

The father reported on 7/13/21, he was outside with the child burning brush and lawn debris when the father walked away from the fire. The father heard a "pop" and ran toward the fire where he observed the child to be on fire. The child was transported to the hospital by the paternal grandmother who lived nearby. The child was airlifted to another hospital for a higher level of care. The child was placed on a ventilator; however, was declared deceased on 7/15/21 at 10:06 PM. The father denied the child had mental health diagnoses that required the child to be constantly supervised. The siblings were inside at the time of the fatal incident and did not witness the explosion.

ACDSS interviewed collateral contacts including the child's mental health provider, his school, the mother, and the paternal grandmother. There were no concerns the child's mental health diagnoses would require the child to have constant supervision and they did not have concerns for the child or siblings' safety.

ACDSS conducted thorough interviews with the family and collateral contacts and documented casework activity timely. Required reports and Safety Assessments were completed with accuracy. The 24-hour Fatality Report was documented timely; however, was approved untimely on 9/1/21.

ACDSS unsubstantiated the allegations of Inadequate Guardianship, Lack of Supervision, Burns and DOA/Fatality against the father regarding the child. ACDSS' investigation revealed the father was outside with the child and although he was not directly watching the child at the time of the fatal incident, the level of supervision was appropriate for a 14-year-old child with experience around fires. There was no credible evidence the father failed to provide the child with a minimum degree of care and he immediately sought out medical attention for the child.

PIP Requirement
No PIP is required as the safety was assessed and the 24-hour Fatality Report not being approved on time had no impact on the safety of the surviving siblings.

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

Explain:
The decision to close the case was appropriate.

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:
Casework activity was commensurate with case circumstances.

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:	Although a 24-hour Fatality Report was documented timely, the report was approved untimely on 9/1/21.
Legal Reference:	CPS Program Manual, Chapter 6, K-1

Child Fatality Report

Action:	ACDSS must document and approve a 24-Hour Fatality Report within 24 hours of receipt of a report alleging the death of a child resulting from abuse or maltreatment. The template for this report is available in Connections for all reports containing an allegation of a child fatality.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/15/2021 **Time of Death:** 10:06 PM

Date of fatal incident, if different than date of death: 07/13/2021
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Allegany
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
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: Tending to fire

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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	14 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	52 Year(s)
Deceased Child's Household	Sibling	No Role	Male	16 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Other Household 1	Mother	No Role	Female	39 Year(s)

LDSS Response

On 7/14/21, ACDSS received an SCR report regarding the child's injuries caused when he put a can of acetone on a fire. The following day, ACDSS received three fatality reports from the SCR. Immediately after receiving the initial report, ACDSS contacted law enforcement. Within the first 24 hours of receiving the fatality report, ACDSS assessed the safety

of the siblings, documented a CPS history check and contacted the sources of the reports. The medical examiner and district attorney's offices were made aware of the death. Information was gathered that the child sustained burns on 50% of his body, was sedated and on a ventilator prior to his passing.

The father was interviewed at the hospital. In 2019, the father obtained custody of his children from the mother, who lived out-of-state. In July of 2020, the child chose to return to live with the mother and was soon placed in Foster Care for the mother's ongoing failure to meet a minimum degree of care. The father learned the child was in Foster Care and the child returned to the father's care. The child had mental health diagnoses, was in counseling and on medication. The father explained on the day of the fatal incident, he was burning yard debris and boxes with the child while the siblings were inside. The father walked away from the fire and heard a loud pop and ran to the fire. The child had taken off his clothes and the father threw the child into the pool. The father called the grandmother who transported the child to the hospital. The father found a bottle of acetone and did not know where it came from, and suspected it was inside one of the boxes that was being burned.

On 7/14/21, a home visit was made alongside law enforcement. The siblings said they were inside watching tv when the explosion occurred. Although they did not witness the child putting the acetone in the fire, they reported the child jumped into the pool and then got into the shower before going to the hospital.

ACDSS contacted the child's mental health provider who said the father was proactive with the child's counseling and was a positive influence on the children. The child appeared happy living with the father. ACDSS interviewed school staff who reported no concerns for the child or siblings and said the father was wonderful and they did not believe the child would require constant supervision. Additionally, the grandmother was interviewed. She received a call from the father who screamed to go to the home immediately and bring the child to the hospital. The child was dressed in a robe when she arrived, and she drove the father and child to the hospital. The mother was interviewed and had no information regarding the incident.

ACDSS offered the family grief counseling services and funeral assistance, both of which were accepted by the family. ACDSS closed their investigation after meeting all casework requirements.

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
Comments: The death was referred to an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058184 - Deceased Child, Male, 14 Yrs	058197 - Father, Male, 52 Year(s)	DOA / Fatality	Unsubstantiated
058184 - Deceased Child, Male, 14 Yrs	058197 - Father, Male, 52 Year(s)	Burns / Scalding	Unsubstantiated
058184 - Deceased Child, Male, 14 Yrs	058197 - Father, Male, 52 Year(s)	Inadequate Guardianship	Unsubstantiated
058184 - Deceased Child, Male, 14 Yrs	058197 - Father, Male, 52 Year(s)	Lack of Supervision	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	☒	☐	☐	☐

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?	☐	☒	☐	☐
Explain as necessary: The siblings did not need to be removed.				

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 siblings were engaged in counseling in response to the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered grief services and funeral assistance in response to the death. The services were utilized.

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? Yes
Were there any siblings ever placed outside of the home prior to this child's death? Yes
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

07/20/05- 10/12/05 The SF was Sub for the IG of the 16-year-old SS and an out-of-state SS and was UnSub for L/B/W of an out-of-state SS.

10/03/05- 01/26/06 The SF was UnSub for IG and XCP of an out-of-state SS and Sub for the IG and XCP of the 16-year-old SS.

11/09/09- 09/24/10 The BM's former partner was Sub for SA regarding an out-of-state SS.

11/18/09- 09/24/10 The BM was UnSub for IG, LS and SA for an out-of-state SS and the 16-year-old SS. The BF of the out-of-state SS was UnSub for L/B/W of that SS.

01/11/10- 09/24/10 The BM was Unsub for IG, LS and SA for the out-of-state SS and the 16-year-old SS. The BF of the out-of-state SS was UnSub for L/B/W and SA of that SS. The BM's then partner was Sub for the SA of the out-of-state SS.

06/07/10- 09/24/10 The BM was UnSub for XOTH of the out-of-state SS and her then partner was Sub for XOTH regarding that SS.

03/10/11- 05/18/11 The SF was Sub for the IG and EXCP of the 16-year-old SS.

09/06/11- 12/02/11 The SF and his then partner were UnSub for IG and L/B/W of the SC.

09/15/11- 12/22/11 The BM and an unrelated home member were UnSub for IF/C/S, IG and LS of the 10 and 16-year-old SSs and two of the out-of-state SSs.

12/23/11- 02/15/12 The BM and unrelated home member were UnSub for IG of the SC and an out-of-state SS and the PD/AM of that SS.

06/26/12- 08/21/12 The BM and the BM's then boyfriend were UnSub for IG, XCP, PD/AM of the SC, 10 and 16-year-old SSs an out-of-state SS.

Known CPS History Outside of NYS

03/18/14- 03/31/14 The mother's children were placed in Emergency Protective Custody by LE due to the unsafe and unsanitary conditions of the home. The mother was substantiated for Physical Neglect of the children and Educational Neglect due to school truancy and Medical Neglect due to lack of medical care.

01/30/17- 03/13/17 The mother was substantiated for Substantial Risk of Physical Abuse due to her substance abuse which affected her ability to meet the needs of the children.

01/23/20- 02/28/20 The mother was substantiated for Physical Abuse against a sibling who was born with a positive toxicology. The child and out-of-state siblings were victims of Physical Neglect.

07/09/20- 08/19/20 The mother and her partner were substantiated for Physical Neglect for the out-of-state siblings and child due to exposure to unsafe living conditions and illegal drug activity. The home was infested with cockroaches and clutter. The adults were not practicing safe sleep and there were concerns for Sexual Abuse.

Preventive Services History

A Preventive Services Case was opened from 9/21/10- 02/22/12. The mother was pregnant and overwhelmed with caring for her children while their fathers were incarcerated. Prior to the case being opened, a sibling was sexually abused by the mother's former partner and was acting out behaviorally as a result. The sibling was enrolled in counseling and ACDSS monitored the family and assisted the mother with casework counseling, counseling programs and transportation. The case

was closed when the mother and children moved to South Carolina. ACDSS contacted South Carolina CPS who assessed the family and their new home prior to the case being closed.

Foster Care Placement History

In March 2014, the children were removed from the care of the mother via an Emergency Protective Custody Order in South Carolina and were placed in Foster Care. The mother was not providing a minimum degree of care to the children. The children were returned to the mother on an unknown date; however, in July 2020, the children were placed in Foster Care again as the mother gave birth to the youngest sibling who tested positive for marijuana. Additionally, the mother did not comply with treatment services, had a dirty home and did not have ample food for the children. The mother was not following the safety plan. The father filed for custody upon learning the child was in Foster Care and the child was returned to the father's care on 9/21/2020 after a court hearing. The judge ordered a continuance of placement for the out-of-state siblings and the mother was granted supervised visitation.

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