Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-19-014

Prepared by: New York City Regional Office

Issue Date: Aug 05, 2019

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

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

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

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

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

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

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

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

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

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

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

Abbreviations

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

Office of Children and Family Services

Child Fatality Report

Case Information

Report Type: Child Deceased
Jurisdiction: New York
Date of Death: 02/09/2019
Age: 4 year(s)
Gender: Female
Initial Date OCFS Notified: 02/09/2019

Presenting Information

On 2/9/19, the SCR registered three reports alleging the 4-year-old SC was left in a bedroom unsupervised with her 11-year-old sibling who had developmental delays. The reports stated the SC fell out of an unsecured window from the fourth floor of the family's apartment. The SC was transported to the hospital and was pronounced dead at 5:26 P.M.; as she sustained an open fracture on the left side of her head and had significant head trauma.

Executive Summary

The SC was 4 years old when she died on 2/9/19. The autopsy report listed the cause of death as blunt impact injuries of head and the manner of death as an accident (fell from height).

The SC resided with her parents, two siblings, and a maternal cousin (MC) who was the home care provider (HCP) for the 11-year-old sibling. At the time of the SC's death, the father was at work. The MA was who stayed with the family every weekend was present. The father of the 11-year-old sibling was very involved with his child and all the adults shared a positive relationship.

On 2/9/19, the SCR registered three reports regarding the death of the SC. The allegations of the reports were DOA/FATL and LS of the SC by the mother and the MA; and IG of the SC by the parents and the MA. The reports also listed LS and IG of the 11-year-old sibling by the MA and IG by the mother.

At the time of the incident, the mother took a muscle relaxer and asked the MA to watch the children while she slept. The SC and the 2-year-old sibling were in the living room watching television. The 11-year-old sibling was alone in a bedroom where there was a bunk bed located near a window. The bottom of the window had an air conditioner and the top of the window was open. The SC was running around and went into the bedroom with the 11-year-old sibling. The SC climbed on the top bed and fell out the window. At approximately 4:55 P.M., the MA looked out the window and saw the SC lying unconscious on the ground in the back of the building complex where the family resided. The family called 911 and the SC was transported to the hospital where she was pronounced dead.

ACS initiated the investigation timely and assessed the siblings were safe in the care of the parents and extended family members. There were other windows in the home that did not have window guards; however, the parents immediately addressed this issue.

ACS learned the father had two older children who resided upstate and contacted the LDSS who confirmed these children were safe in their mother's care. Their mother had no concerns about the children spending time in NYC with father.

The 11-year-old sibling spent time with his father on a regular basis and stayed with him after the fatality. ACS assessed his home and had no concerns about his ability to care for the sibling.

ACS adequately assessed the children's safety, but did not properly complete the instrument for all the required safety assessments.

ACS made all relevant collateral contacts for the children's medical and special needs and there were no concerns about abuse or neglect of any of the children.

ACS referred the family to New Alternatives for Children for PPRS and the family accepted the services.

On 4/23/19 ACS unsubstantiated the allegations of DOA/FATL and LS of the SC by the mother and the MA citing the NYPD ruled the SC's death an accident and there was no credible evidence to support the allegation of LS. ACS unsubstantiated the allegation of IG of the SC by the MA also citing there was no credible evidence.

ACS unsubstantiated the allegation of IG of the 11-year-old sibling by the mother and the MA, and LS by the MA citing there was no credible evidence to support these allegations.

ACS substantiated the allegation of IG of the SC by the parents because it was discovered they occasionally left the top window in the children's bedroom open which was in close proximity from the bunk bed. ACS learned the SC was known to be a climber and on the day of the incident she fell out of this window after climbing on the top bunk.

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?** — No
  - **Safety assessment due at the time of determination?** — Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** — No

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? — 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:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment

Summary:	Neither the safety decision nor the selected safety factors were consistent with the case documentation.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	ACS did not complete the required 30 Day Safety Assessment due at the time the 30 Day Report was completed.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The 24 Hour Safety Assessment was not approved timely. In addition, the selected safety decision and the selected safety factors were not consistent with the information gathered.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Appropriateness of allegation determination
Summary:	The allegations of DOA/FATL and LS were unsubstantiated because the death was ruled an accident; however, the accident occurred due to the caretakers lack of supervision and parents' failure to properly secure the windows to protect the children.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 02/09/2019 **Time of Death:** 05:26 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 04:45 PM

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used alcohol or drugs? N/A

Child's activity at time of incident:

- [ ] Sleeping
- [ ] Working
- [ ] Driving / Vehicle occupant
- [x] Playing
- [ ] Eating
- [ ] Unknown
- [ ] Other

Did child have supervision at time of incident leading to death? Yes

At time of incident supervisor was:

- [ ] Drug Impaired
- [ ] Absent
- [ ] Alcohol Impaired
- [ ] Asleep
- [x] Distracted
- [ ] Impaired by illness
- [ ] Impaired by disability
- [ ] 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	Aunt/Uncle	Alleged Perpetrator	Male	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	31 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Other Adult - cousin	No Role	Female	22 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	11 Year(s)

LDSS Response

According to the NYPD, the 911 call was made at 4:55 P.M., they received the call from dispatch at 5:01 P.M. and arrived at the case address at 5:02 P.M. The NYPD found the SC with no pulse, and administered CPR until EMS arrived. The family told the NYPD the SC sometimes climbed on the top bunk bed that was near a window in the children’s room. The NYPD stated the window opened from the top and the bottom, but the family had an air conditioner on the bottom window which prevented the SC from opening the window. Therefore, the SC fell out the top window that had been left open by the parents due to the high temperature in the room. The NYPD determined there was no criminality involving the death of the SC by the family.

The staff from Lincoln Hospital stated the SC arrived at the hospital at 5:11 P.M. and pronounced dead at 5:26 P.M. The medical staff noted the SC died as a result of the fall.

ACS found the home orderly with adequate provisions for the all the children. The 2-year-old and the SC had toddler beds, the 2-year-old’s bed was in the parents’ room and the SC’s bed was in the bedroom she shared with the 11-year-old who slept on a bunk bed. The bunk bed was very close to the window. ACS measured the distance between the top bunk and

the window, to assess the feasibility for the SC to jump from the bed to the open window. According to the measurements, the bedpost to the open window was 2 feet and 7 inches apart, and the distance from the bedpost to the wall was 1 foot. The family reported the window was open about three and a half inches; and the SC was 40 inches tall.

The mother said on 2/9/19, she woke up at 9:00 A.M., and she fed and took care of the children. Sometime later the MA and the MC woke up; the father woke up at about 1:30 P.M. and left for work at 2:45 P.M. The mother said shortly after the father left the home, she took her medication and asked the MA to watch the children while she rested. The mother said she was awakened by the MA because the MA nor the MC could find the SC in the home. The mother said they all began looking for the SC until the MA looked out the window in the children's room and saw the SC on the ground in the back of the building. The mother said she told the MA to call 911 and went downstairs to look for an entrance to the back of the building until EMS arrived.

The MA corroborated the mother's account and said that after the mother went to take a nap, she was in the living room with the MC and the 2-year-old sibling watching television; the SC was going back and forth from the living room to her room where the 11-year-old sibling was playing with his tablet. The MA said she and the MC were checking the children randomly, but at an unspecified time, the MC went to the room to check the children and found the SC was not there. The MA said she woke up the mother and they all looked for the SC in the home but they were unable to find the SC until the MC noticed the top window in the room was open. The MA climbed and looked out from the top window then saw the SC's body on the ground with no movement. The MA said she screamed out to the mother and then called 911. When asked about the relationship between the SC and the 11-year-old, the MA explained they sometimes played with their toys together, however, the sibling did not understand much because he had a functioning level of a 4-year-old. The MA said the 11-year-old would not have been able to lift the SC as he could not use the left side of his body. The MA said the SC liked to climb and must have climbed onto the top bunk on her own. The MC corroborated the MA's account.

The father said on 2/9/19 he left the home to go to work at 2:45 P.M. and received a call from the MC at 4:53 P.M. who informed him of the incident. The father reported he left his job at 6:00 P.M. and was informed of the SC's death once he arrived at the hospital.

ACS indicated 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: There was no documentation of an MDT investigation; however, the investigation adhered to previously approved protocols for joint investigation.

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

SCR Fatality Report Summary

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

049212 - Deceased Child, Female, 4 Yrs	049217 - Aunt/Uncle, Male, 18 Year(s)	Lack of Supervision	Unsubstantiated
049212 - Deceased Child, Female, 4 Yrs	049217 - Aunt/Uncle, Male, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
049212 - Deceased Child, Female, 4 Yrs	050872 - Father, Male, 31 Year(s)	Inadequate Guardianship	Substantiated
049212 - Deceased Child, Female, 4 Yrs	049213 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
049212 - Deceased Child, Female, 4 Yrs	049217 - Aunt/Uncle, Male, 18 Year(s)	DOA / Fatality	Unsubstantiated
049212 - Deceased Child, Female, 4 Yrs	049213 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
049212 - Deceased Child, Female, 4 Yrs	049213 - Mother, Female, 31 Year(s)	Lack of Supervision	Unsubstantiated
049215 - Sibling, Male, 11 Year(s)	049217 - Aunt/Uncle, Male, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
049215 - Sibling, Male, 11 Year(s)	049213 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Unsubstantiated
049215 - Sibling, Male, 11 Year(s)	049217 - Aunt/Uncle, Male, 18 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

7-All the children were non verbal.

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?	☐	☐	☒	☐

Explain:
The 24-Hour Safety Assessment was not completed timely. The safety decision and the selected safety factors selected for each of the 24 Hour and 7-Day safety assessments were not reflected in the case documentation. ACS did not complete a 30 day safety assessment.

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:
N/A

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	☒	☐	☐	☐	☐	☐	☐
Other, specify: PPRS							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
The surviving children were not in immediate needs of services in reponse to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The parents were not in immediate need of services in response to the fatality.

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 9/24/08, the SCR registered a report with allegations of LMC and IG of the now 11-year-old sibling by the mother. The report was indicated and referred for PPRS.

On 4/29/2013, the SCR registered a report with allegations of L/B/W and IG of the now 11-year-old sibling by the mother. The report was unfounded on 6/27/13.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Preventive Services History

The family was referred to the New Alternatives for Children by ACS on 12/5/08, as the now 11-year-old sibling was at risk of being placed in foster care and the family's housing was unstable. The family received casework counseling, diagnostic evaluation, case management, early intervention and parenting skills for children with special needs. The case was closed on 3/2/10 because the family was not complying with the agency's appointments or home visits. However, the now 11-year-old sibling was attending medical appointments and all his services were in place.

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