Child Fatality Report

Report Identification Number: NY-21-109

Prepared by: New York City Regional Office

Issue Date: Apr 08, 2022

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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 10/08/2021
Initial Date OCFS Notified: 10/08/2021

Presenting Information

The SCR registered an initial and two subsequent reports regarding the fatality. The reports alleged on 10/8/21, the BM took the SC to the MA's home to be cared for while she was at work. The MA regularly cared for the SC and was aware that the SC had a developmental delay and recently underwent surgery due to him falling off the bed at the GMA's home. At an unspecified time in the morning of 10/8/21, the MA left the SC unsupervised in a room in the home. The room had a window that was open and covered by some cardboard. At an unknown time, the MA realized the SC had gone missing from the home. At 10:20AM, a bystander found the SC laying on the concrete in the courtyard after falling from the 4th floor apartment window. EMS was called and responded with the police. CPR was performed at the scene as the SC had suffered cardiac arrest because of the fall. The SC was transported by ambulance to the hospital where he died from his injuries.

Executive Summary

This fatality concerns the death of a 3-year-old SC who fell out of a fourth story window onto the concrete pavement. The SC was in the care of his MA/babysitter when the incident occurred. The MA's five children were present in the home at the time. EMS and LE responded to a 911 call by the building staff. The SC was transported to the hospital where he was later pronounced DOA. The ME reported that the preliminary cause of death was blunt force trauma pending toxicology reports.

At the time of the incident, the SC resided with his BM and the SS. The BF resided at a different address and was involved with the family. The SS father resided in upstate New York and was involved with the SS.

On 10/8/2021, ACS received the report and initiated the CPS investigation in a timely manner. ACS investigation revealed on the day of the incident, the MA was doing home-schooling with some of her children in the living room when the incident occurred.

The SC and the MA's 5-yo son were running back and forth from the living room to the 12-yo's bedroom. At some point, the MA went to check for the 2 children in the room and did not find the SC. She began looking for the SC throughout the home. She went to the 12-yo's bedroom and noticed that the cardboard and duct tape that was used to fasten the air conditioner (AC) unit for the past 4 years was moved. The MA was on a phone call with her mother at the time and told her mother she could not find the SC anywhere in the home. The MA called her husband and told him the same thing. She then ran downstairs and asked the building staff to check the back of the building as she could not find the SC. The staff led the MA to the back of the building where they found the SC on the concrete floor unresponsive. The building staff called 911. LE and the ambulance arrived and transported the SC to the hospital.

ACS obtained information from pertinent collaterals such as LE, the ME, hospital staff and school staff. LE and the ME stated the initial findings indicated the fatality appeared accidental. LE did not make any arrests. Based on the forensic interview of the MA's older children, it appeared the SC had been running around, and jumping on the bed prior to him falling out of the window. Also, ACS conducted virtual and home visits to assess the family. ACS deemed the SS and the MA's children safe in the care of their caretakers. The family did not report any concerns about the MA's parenting. The MA's account of the incident was consistent throughout the investigation.

ACS held two separate child safety conferences (CSC) for the BM and the MA's family. The outcome of each CSC was to

not seek court intervention. The CSCs referred the family to services.

On 12/7/2021, ACS unsubstantiated all the allegations of the report. ACS determined there was no indication that the MA's actions or inactions placed the SC at risk of any physical or developmental harm. The ME's preliminary findings indicated the cause of death was blunt force trauma to the head pending toxicology reports. The SC's injuries were caused because of the SC falling out of the four-story window. LE reported the SC's death appeared accidental and did not make any arrests.

ACS should have substantiated the allegation LS of the SC by the MA. The MA failed to provide adequate supervision for the SC in her home while caring for him which resulted in the SC falling to his death out of the window from a room which did not have window guards and appropriately installed AC. The MA was aware that the SC needed more attention and supervision.

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?** 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?** No

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS opened the case for service.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination

Summary:	ACS should have SUB the allegation IG of the SC by the MA. The MA failed to provide adequate supervision for the SC in her home while caring for him which resulted in the SC falling to his death out of the window.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 10/08/2021 **Time of Death:** 10:55 AM

Time of fatal incident, if different than time of death: 10:23 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 10:23 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☒ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ 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	3 Year(s)
Deceased Child's Household	Father	No Role	Male	45 Year(s)
Deceased Child's Household	Mother	No Role	Female	36 Year(s)

Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Male	28 Year(s)
Other Household 1	Other Adult - MA's Husband	No Role	Male	36 Year(s)
Other Household 1	Other Child - MA's Child	No Role	Female	7 Year(s)
Other Household 1	Other Child - MA's Child	No Role	Male	5 Year(s)
Other Household 1	Other Child - MA's Child	No Role	Female	3 Year(s)
Other Household 1	Other Child - MA's Child	No Role	Male	5 Month(s)
Other Household 1	Other Child - MA's Child	No Role	Female	12 Year(s)

LDSS Response

On 10/8/2021, LE stated the MA was interviewed and based on the initial findings, the fatality appeared accidental.

On 10/8/2021, ACS also interviewed the MA, and her account of the incident was consistent with the information that was already known. She disclosed the SC was autistic and that on 10/6/21, the SC was seen at the ER and discharged after he sustained injuries from falling off the bed at the GPA's home. ACS then assessed the MA's two youngest children to be free of any visible marks or bruises.

On 10/8/2021, the MA's three oldest children were forensically interviewed, and their statements indicated the SC had been running around and jumping on the bed prior to him falling from the window.

On 10/8/2021, ACS virtually assessed the SS and did not document any concerns for her. The SS denied physical discipline in the home.

On 10/8/2021, the BF reported he last saw the SC on 10/4/21, and that he was aware the SC had received some stitches because he fell in the GPA's home. The BF stated the ER doctor (Dr.) reported the SC sustained fatal injuries from the fall, resulting in his death. The BF denied he had any concerns for the SC's care prior to the incident.

On 10/8/2021, the PGM of the MA's children did not report any concerns for the MA as a mother. ACS assessed the PGM's home to be free of any hazards. ACS discussed safe sleep with the PGM as the MA's 2 youngest children would be temporarily staying with their PGM.

On 10/11/2021, the SS's school did not report any academic or behavioral concerns for the SS.

On 10/12/2021, the BM reported the SC was nonverbal and autistic. The SC had received EI services and therapy. She stated the children were up to date with their physicals and immunizations. She did not report any concerns for the SC in the MA's care prior to the incident. ACS assessed the SS and deemed her safe in the care of her BM. The SS denied physical discipline by her parents.

On 10/13/2021, the MA's husband denied physical discipline of his children. He also denied any concerns for his children in the MA's care.

On 10/14/2021, ACS assessed the MA's younger children at their PGM's home and did not observe any concerns in the home.

On 10/14/2021, ACS held two separate child safety conferences (CSC) for the BM and the MA's family. The CSCs did not seek court intervention. The BM and the MA were referred to services.

On 10/15/2021, school staff did not report any concerns for the SS.

On 10/15/2021, the ME reported based on initial findings, the cause of death was blunt force trauma to the head pending toxicology.

On 10/19/2021, ACS virtually assessed the MA's three older children and did not document any concerns for them. ACS received the MA's children's medical records which reflected they were current with their immunizations and kept their appointments. The medical provider did not report any concerns regarding the medical care the children received. ACS provided the MA and the BM with information regarding services.

Between 10/28/2021 and 12/6/2021, ACS made multiple casework contacts with the MA, the BM, and other collaterals. There was no new information about the fatality. ACS assessed the SS and the MA's children to be safe in the care of their caretakers. ACS held a follow-up CSC with the MA. She stated the family was receiving services and they were doing well. She had re-arranged the home and the AC units in the home had been properly secured. The MA thanked ACS for the support provided. ACS also held a separate follow up CSC with the BM's family. The BM stated they were doing well. The SS would receive counseling services at her school. The BM thanked ACS for the referrals and the support.

Official Manner and Cause of Death

Official Manner: Unknown
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: There is no OCFS approved Child Fatality Review Team in New York City.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060024 - Deceased Child, Male, 3 Yrs	060027 - Aunt/Uncle, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
060024 - Deceased Child, Male, 3 Yrs	060027 - Aunt/Uncle, Male, 28 Year(s)	Fractures	Unsubstantiated
060024 - Deceased Child, Male, 3 Yrs	060027 - Aunt/Uncle, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
060024 - Deceased Child, Male, 3 Yrs	060027 - Aunt/Uncle, Male, 28 Year(s)	Internal Injuries	Unsubstantiated
060024 - Deceased Child, Male, 3 Yrs	060027 - Aunt/Uncle, Male, 28 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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

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

The BM was a subject in an SCR report dated 12/1/2011. The report alleged the BM and 4 other adults in the home all smoked marijuana, used cocaine, and drank alcohol to impairment daily while being the sole caretakers for their 7-8 unnamed children (ages 8 months-15 years). The home was unsanitary and there was no food for the children, as they were missing meals as a result. The adults were smoking marijuana leaving clouds of smoke in the home, placing the children at risk of getting under the influence. The adults were beating the children about their lower bodies for discipline purposes. The children had marks and bruises on their bodies as a result. The children were also not bathed regularly. They did not have no clean clothes and had a foul smell.

ACS conducted home visits and interviewed the adults and children in the home. They denied the BM lived in the home. The home did not pose any health or safety hazards for the children. They were observed to be free of marks and bruises. Additionally, the BM submitted for a drug screening and was negative for all drugs and alcohol.

On 1/29/2012, ACS UNSUB the allegations EXCP, IFCS, INGD, LABW, and PDRG.

The MA did not have prior history as a parent.

Known CPS History Outside of NYS

Neither the BM nor the MA have any known CPS history outside of New York State.

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