Child Fatality Report

Report Identification Number: NY-20-058

Prepared by: New York City Regional Office

Issue Date: Dec 01, 2020

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: 5 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 06/24/2020
Initial Date OCFS Notified: 06/24/2020

Presenting Information

According to the OCFS-7065, the five-year-old male child was in the hospital from 6/22/20. He remained hospitalized until he was pronounced dead on 6/24/20.

Executive Summary

The family had an open CPS investigation that began on 6/22/20. The report alleged the child, who was non-verbal and had developmental disabilities, fell from a window due to inadequate supervision by the BM and MGM. The child sustained serious injuries when he fell from a window, and was hospitalized but was not expected to survive. There were no other children in the household. The BF did not reside with the family, but he had an informal child visitation arrangement with the BM.

ACS interviewed household members, medical professionals and LE and verified that on 6/22/20, between 8:30 PM and 9:00 PM, the BM placed the child to sleep in his bedroom. The BM then went to another room and the MGM sat in a chair to supervise the child in his bedroom. The MGM fell asleep and the child climbed onto the top of the bed frame, to a window opening and fell out the window. ACS progress notes showed at the time the SC sustained the fall, the window was open at the top although the lower section of the window was closed and locked. A bystander called 911 and EMS responded. The MGM awoke, discovered the child was not in his bed, and alerted the BM. The BM and MGM overheard voices outside their window, observed bystanders and became aware the child sustained a fall. The MGM and BM also called 911, and went outside where they heard the child's cries.

ACS verified that EMS transported the child to the hospital. The medical professionals said the child arrived at the hospital at 9:30 PM, and upon arrival he was alert and crying. However, his condition deteriorated, and the medical professionals diagnosed him with a skull fracture, brain swelling and bleeding of the brain, traumatic brain injury, and an abrasion to the right ankle. The hospital placed the child in a medically induced coma and admitted him to the pediatric intensive care unit. On 6/24/20, the hospital informed ACS the medical examinations revealed the child had no brain activity. The child was pronounced dead by the attending physician.

ACS submitted the OCFS-7065 Agency Reporting Form for Serious Injuries, Accidents or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Services Cases. The information regarding the child's death was reported to OCFS under Chapter 485 of the Laws of 2006.

The child had two adult female, and one male infant surviving half sibling who resided with his mother out of New York State. ACS contacted officials and requested a wellness check for the infant half sibling. The officials informed ACS that there were no concerns about the care the mother provided the infant.

ACS provided the family with referrals for community-based services and closed the case as there were no surviving children in the BM's household.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

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:
N/A

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: 06/24/2020 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 06/22/2020
Time of fatal incident, if different than time of death: 08:30 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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
☐ Playing ☐ Eating ☒ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	No Role	Male	5 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	69 Year(s)
Deceased Child's Household	Mother	No Role	Female	33 Year(s)
Other Household 1	Father	No Role	Male	41 Year(s)

LDSS Response

On 6/24/20, ACS discussed the case circumstances with the ME's office. During the discussion, ACS learned that the autopsy was pending the results of an additional assessment of the location of the window in the child's bedroom. The ACS progress notes showed, while it was plausible the child climbed out the top window using the curtain, it was necessary to verify whether or not the child climbed out of the bottom section of the window.

ACS reviewed the case circumstances which reflected the child had developmental disabilities and was very active. According to the parent's account, the child had a history of climbing and the BM kept the bottom of the window in a closed position and only opened the top window. Regarding the day of the incident, on 6/22/20, the child was in the BF's care until approximately 12:00 PM, when the BF dropped the child at the BM's home. The BM informed ACS that she worked from home and the MGM assisted with supervising the child. The BM said she placed the child in his bed at approximately 8:00 PM. She said the MGM fell asleep and when she awoke, she called the child's name, and the MGM and BM did not see the child. The BM explained that there was a crowd outside, and when she went outside she saw the child and he was crying.

ACS progress notes showed the medical professionals said the child fell from a second-floor window, sustained fracture to his head and multiple brain bleeds, and the hospital placed him in a medically induced coma. The professionals said the explanation provided for the injury was consistent with a fall from a window. The hospital performed medical examinations, declared the child was brain dead and subsequently the child was pronounced dead.

On 6/24/20, ACS held a conference with the investigative consultant, who requested pictures and videos of the home and the child's bedroom, where the child sustained the fall. ACS discussed plans to obtain the 911 calls and database checks of the BM, BF and MGM. On 6/26/20, ACS determined it was necessary to conduct a welfare check of the surviving half-sibling who resided with his mother out of New York State, offer the family bereavement services and obtain consultations regarding the case circumstances.

On 7/10/20, ACS interviewed the ME to obtain an update on the autopsy report. According to the ME's account, preliminary findings showed the cause of death was listed as blunt impact injuries to the head (immediate), and the manner of death was listed as accidental.

On 7/23/20, ACS received information from the official who conducted a wellness check for the surviving infant half-sibling. The officials reported there were no concerns regarding the half-sibling and his mother.

The BF contacted ACS and stated the family cremated the child. ACS offered the BF referrals for bereavement. According to the ACS case record, the BF was willing to accept the referrals that ACS sent by postal mail.

In an Investigation Progress Note dated 7/24/20, ACS noted the review of the case circumstances showed the child's death was accidental. ACS closed the case and ended contact with the family.

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 reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in New York City.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
Pediatrician	☐	☐	☐	☒
Was a death-scene investigation performed?	☒	☐	☐	☐
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?	☐	☒	☐	☐

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? N/A
Explain:
There were no surviving children in the BM's care.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS referred the family to community-based organizations for bereavement.

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?	N/A
Was the child acutely ill during the two weeks before death?	Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/23/2020	Deceased Child, Male, 5 Years	Mother, Female, 33 Years	Fractures	Unsubstantiated	No
	Deceased Child, Male, 5 Years	Mother, Female, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 5 Years	Mother, Female, 33 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 5 Years	Mother, Female, 33 Years	Swelling / Dislocations / Sprains	Unsubstantiated	
	Deceased Child, Male, 5 Years	Grandparent, Female, 69 Years	Fractures	Unsubstantiated	
	Deceased Child, Male, 5 Years	Grandparent, Female, 69 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 5 Years	Grandparent, Female, 69 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 5 Years	Grandparent, Female, 69 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Report Summary:
On 6/22/20, at approximately 8:00 PM, the five-year-old child was in the home with the BM and MGM. The BM and MGM were aware the child was non-verbal, had developmental disabilities, and required a higher level of supervision, as a result. The BM and MGM did not adequately supervise the child in the home. As a result of the adults failing to adequately supervise the child; the child climbed to the top of the bed post which was in front of the window. The child fell from the second-floor window to the ground. The child sustained a skull fracture, brain bleed, swelling and an abrasion over his left ankle. The child was in a critical condition. The role of the BF was unknown.

Report Determination: Unfounded | **Date of Determination:** 07/24/2020

Basis for Determination:
ACS unfounded the report on the basis the LE, medical specialist, and ME ruled the death accidental. ACS explained that the child sustained injuries when he fell from the window, his condition worsened and there was a low expectation of survival. ACS was unable to find evidence that the BM and MGM were not able to meet the child's minimum degree of care.

OCFS Review Results:
ACS interviewed the BM, MGM, BF, LE, medical personnel, ME and other collateral contacts. ACS' findings showed on 6/22/20, at approximately 8:30 PM, the MGM was in the child's room and the BM was in another room. The MGM fell asleep, the child climbed on top a bed frame, fell from the window, and landed on the back of his head sustaining serious injuries. EMS responded and transported him to the hospital where he received treatment for his injuries. On 6/23/20,

ACS visited the hospital, observed the child and noted he had no movement. The hospital informed ACS of the child's death on 6/24/20. ACS visited the home and found the family provided a minimum degree of care for the child.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No