NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: NY-16-070 **Prepared by: New York City Regional Office**

Issue Date: 12/27/2016

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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 07/03/2016
Initial Date OCFS Notified: 07/02/2016

Presenting Information

The 7/3/16 SCR report alleged on 7/3/16 at approximately 7:13 PM, the 3-year-old male child, who had been playing with his sibling, fell from a 13th floor window. He was found in traumatic arrest on the ground. He was pronounced dead at Harlem Hospital. The mother was asleep on the couch, and the father was not home. The mother heard a thump and discovered the child had fallen out the window. The window guard was discovered next to the child's body. The child was pronounced dead at 7:36pm. The father had an unknown role.

Executive Summary

This 3-year-old male SC died on 7/3/16. The allegations of the 7/3/16 report were DOA/Fatality and IG of the SC by the SM. According to the ME, no autopsy was done due to the family's religious objections.

On the evening of 7/3/16, when the SM arrived home from work, the SC and the surviving twin (ST) were in the living room with the PA. The SC and ST were playing. Later, the SM went into the living room when she heard the PA's scream. She looked outside the window and observed the SC lying on the ground. The PA called the BF to inform him the SC fell from the apartment window. The BF returned to the building and observed the efforts of the first responders to revive the SC. The PA stayed at the home with the ST while the SC and SM were transported to Harlem Hospital. The SC was pronounced dead shortly after arrival.

According to the ACS record, the family was subletting the one bedroom public housing apartment since 2014. Due to the parents' work schedules, the PA often provided supervision of the SC and ST. The parents disclosed that since 2012 three older surviving siblings (SS) resided with the PGP's out of the country.

ACS staff gathered pertinent information about the circumstances surrounding the SC's death and obtained statements from the parents and PA. Appropriate collateral contact was made to the day care and medical providers of the SC and ST.

ACS offered bereavement assistance and PPRS services; however, the parents declined due to their cultural beliefs. The parents accepted the referral for early intervention, speech and occupational therapy service for the ST. A Family Services Stage (FSS) was opened on 7/11/16.

On 11/10/16, ACS unsubstantiated the allegations of DOA/Fatality and IG of the SC by the SM on the basis that there was no credible evidence to support the allegations. ACS added and substantiated the allegation of IG of the SC by the PA; the SC and ST were in the care of the PA at the time of the incident. According to ACS the PA dozed off while the children were playing. ACS did not add IG or LS of the ST by the PA although the same circumstances applied to the ST. ACS did not approved the 30-Day report or the corresponding safety assessment in a timely manner.

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

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:
The determination made by ACS to indicate the report was appropriate.

Required Actions Related to the Fatality

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

Issue:	Failure to provide notice of report
Summary:	The documentation did not state that the PA, who was a subject of the report, was provided a Notice of Existence.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations 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.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	Documentation of efforts to contact with first responders was not observed.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations 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.

Issue:	Failure to Provide Notice of Indication
Summary:	The notice of indication was not documented to have been provided to the SM, PA and BF.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	ACS must submit a corrective action plan within 45 days that identifies the action the agency will take or took to address the citations 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: 07/03/2016 **Time of Death:** 07:36 PM

Time of fatal incident, if different than time of death: 07:09 PM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 07:12 PM
Did EMS to 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? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 2
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Father	No Role	Male	36 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)
Other Household 1	Sibling	No Role	Female	7 Year(s)
Other Household 1	Sibling	No Role	Male	5 Year(s)
Other Household 1	Sibling	No Role	Female	9 Year(s)

LDSS Response

On 7/3/16, LE deemed the home a crime scene. LE observed the home had food and was untidy. The PA said the SC and ST were in the living room with her; the SM had arrived home from work and was in the bedroom. The bed was near the window and bags of clothes provided a 2ft space between the bed and the window. The PA heard a sound, looked up and saw SC fall through the open window. The PA alerted the mother. The BF was not home when the incident occurred. No arrests were made and the investigation was ongoing. The parents were interviewed at the precinct.

On 7/3/16 the family permanently relocated to the MGP's home. ACS assessed the SS for safety. The Specialist observed the ST, was free of any visible marks or bruises and the home was deemed safe.

On 7/4/16, the family objected to an autopsy due to religious belief. The ME conducted a visual exam of the SC. The ME reported the SC sustained multiple fractures to the skull, had minor scrapes and cuts on the rest of the body. The injuries were consistent with a fall from the height reported. The ME had no homicidal suspicions or child abuse concerns.

On 7/5/16. the EMS liaison stated the 911 call was received at 7:12pm on 7/3/16. EMS arrived to the scene at 7:16 PM. Upon EMS' arrival, FDNY was observed on site and had performed CPR on the SC. EMS was informed the SC fell out of the window and hit an air conditioner on the way down. EMS left the scene at 7:21 PM, arrived at Harlem Hospital at 7:26 PM and the SC was pronounced dead at 7:36 PM.

ACS interviewed the parents and PA separately. The BF said he was not in the home at the time of the incident. The PA said she was awakened when she heard a loud noise. She looked towards the window and noticed the window guard was no longer attached. She looked outside the window and observed the SC was lying outside on the ground. There were no inconsistencies in the statements provided.

On 7/5/16, the DC director said the SC and ST attended regularly and were in the referral stage for evaluation due to concerns of speech delay. The parents were receptive and were looking forward to the evaluation. There were no concerns regarding the care the parents provided to the children.

A neighbor said the family had lived in the apartment for the past year and there were no concerns about the family. The children were observed well dressed.

The lease holder of the apartment stated he allowed the family to temporarily stay in the apartment. The lease holder said the home was appropriate; the window guards and air conditioners remained in place. Lease holder reported no interaction with the children when the home was visited.

On 7/8/16, an Initial Child Safety Conference (ICSC) was held at the LDSS office to discuss the concerns. The parents accepted play and speech therapy service referral for ST at The Learning Center (TLC) The parents declined bereavement counseling and housing referral. The parents expressed they received substantial support from religious leaders. The Specialist noted no concerns with the family.

On 10/21/16, the TLC's director stated the ST had adjusted well to the school. The ST was scheduled to receive speech therapy, occupational and play therapy. There were no concerns regarding the care of the ST received from the parents.

During the investigation, the Specialists made sufficient face to face contact with the family at their temporary residence; to assess and monitor the ST for safety.

On 11/10/16, ACS indicated the report and closed the FSS stage. The reason for the delay of the investigation determination was unclear.

Official Manner and Cause of Death

Official Manner: Unknown
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: 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 New York City region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
029601 - Deceased Child, Male, 3 Yrs	029602 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
029601 - Deceased Child, Male, 3 Yrs	029602 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
029601 - Deceased Child, Male, 3 Yrs	032181 - Aunt/Uncle, Female, 25 Year(s)	Inadequate Guardianship	Substantiated

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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:

The residence was deemed a crime scene by LE. Efforts to contact first responders was not documented. Three older SS's resided out of the country with the PGP's since 2012. The ST was not interviewed due to speech delay.

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 safety 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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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 there an open CPS case with this child at the time of death? 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 family has no CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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