Child Fatality Report

Report Identification Number: NY-22-051

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

Issue Date: Dec 20, 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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		

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: New York
Gender: Male
Date of Death: 07/02/2022
Initial Date OCFS Notified: 07/02/2022

Presenting Information

An SCR report alleged that on 7/2/22, while in the care of the mother and father, the 3-year-old fell out of the living room window. The mother witnessed the child running toward the window and advised the father to call 911. The child fell from the window and fell 28 stories onto the roof of the second floor of the building. The parents were aware that the window was not fully functioning, and that the child was at risk of falling out of the window as a result. The father called EMS at 11:09 AM. As a result of the child falling out of the window, the child was pronounced deceased at approximately 11:31 AM on 7/2/22.

Executive Summary

This report concerns the death of the 3-year-old subject child that occurred on 7/2/22. A report was made to the SCR on the same day with allegations that the child was unsupervised when he fell from the family's home and fell 28 stories before landing on a rooftop. At the time of his death, the child resided with his parents. There were no surviving siblings or other children living in the home.

The Administration for Children Services (ACS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. An autopsy was performed; however, the final autopsy had not yet been received at the time this report was written. The medical examiner's office reported the child's injuries were consistent with the incident that occurred. The criminal investigation remained open awaiting the final autopsy report. The district attorney's office believed the death to be a result of negligence by the parents.

The parents reported they were in their bedroom while the child went back and forth between the bedroom and the living room while he was playing. The parents did not hear the child for a few minutes, so they called out to him. The child did not respond so the parents went to look for him. The mother looked over the balcony and saw the child's body on a roof below. She screamed and told the father to call 911. The parents ran outside while 911 was contacted by an unknown caller. The child was transported to the hospital where he was pronounced deceased. The parents reported the balcony was lined with a mesh lining; however, it was damaged, and they had reported it to the building's management.

ACS gathered information from law enforcement, hospital staff, the apartment building's staff, neighbors, and a cousin. The neighbors stated the parents frequently argued but did not note concerns for the child. The apartment building staff denied knowing the apartment's balcony required maintenance.

ACS conducted home visits and documented thorough interviews. The 24-hour Fatality Report was completed untimely. ACS added and substantiated the allegation of Lack of Supervision. The allegations of Inadequate Food/Clothing/Shelter and DOA/Fatality were also substantiated. ACS determined the parents left the child unsupervised, with access to the balcony, and they were aware the mesh lining was damaged; therefore, the parents were responsible for the child's death.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
A Safety Assessment was not due at the time of case determination as there were no surviving siblings or other children in the home. 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? No

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

Explain:
Casework activity was not commensurate with case circumstances as the 24-hour Fatality Report was completed untimely.

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:	The 24-hour Fatality Report was completed untimely as it was completed more than 48 hours after the receipt of the report.
Legal Reference:	CPS Program Manual, Chapter 6, K-1
Action:	ACS 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

Child Fatality Report

Incident Information

Date of Death: 07/02/2022 **Time of Death:** 11:31 AM

Time of fatal incident, if different than time of death: 11:05 AM

County where fatality incident occurred: New York
Was 911 or local emergency number called? Yes
Time of Call: 11:09 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

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	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)

LDSS Response

On 7/2/22, ACS received the fatality report from the SCR. Within the first 24 hours of the investigation, ACS coordinated investigative efforts with law enforcement, notified the medical examiner and district attorney's offices of the death, contacted the source of the report, and documented a CPS history check.

ACS spoke with the hospital doctor who reported the child was brought to the hospital via ambulance. CPR was performed to no avail. The doctor described the child's face to be pushed in. The child had fractures to his face, skull, and right leg.

Law enforcement provided information they gathered from the parents. The parents told law enforcement that the family had a typical morning, and the child was playing in the living room. The parents had opened the door to the balcony as it was hot inside of the home. Law enforcement reported the mesh lining was broken and detached from the frame. The mother reported she made the building's management aware the mesh needed to be replaced a few months prior; however, the repair was not made. Law enforcement did not report finding criminality regarding the death.

On 7/2/22, the mother was interviewed by ACS. The mother reported the family woke up around 10:00 AM and bathed themselves. Afterward, the child played in the living room while the parents were in the bedroom. The mother realized she could not hear the child playing, so she called out for him. The child did not respond, so the father called for him. After the

child did not reply, the father went to look for the child and returned to the room without him. The mother reported she "just knew" and looked over the balcony and saw the child's body on the scaffold below. She ran outside to the child. The mother reported the mesh lining on the balcony was damaged and she had reported it to the building's management 2 months prior; however, they did not fix it. The mother said although the mesh lining was damaged, she did not think the child would be able to fit through the damaged area.

The father's recollection of the morning of 7/2/22 was consistent with what the mother reported. The father added that prior to the parents going into the bedroom, the father and child were on the balcony together. The child made comments about the yellow car below. The father and child went back inside the apartment, and the father went into the bedroom with the mother. The child was going back and forth between the bedroom and the living room as he played. The child came into the bedroom and asked if the father heard the fire truck outside and left the room again. Approximately 2-3 minutes later, the parents did not hear the child playing and went to look for him. The father was in another room when he heard the mother screaming to call 911. Both parents ran outside, and a patron directed the father to a ladder to reach the scaffold where the mother was with child. The father said the mesh lining was reported to the building's management "all the time", including the day prior to the fatal incident; however, it was not fixed.

ACS spoke with the paternal cousin who said the parents were good parents and there was no concern for the safety of the child. Neighbors reported they heard the mother scream prior to learning what happened to the child. The apartment building manager was contacted. The manager said there was no documentation the family contacted the building maintenance regarding the mesh lining needing to be repaired or replaced.

ACS offered the family bereavement services and burial assistance in response to the fatality. It remained unknown if the family utilized the services. After completing required casework, the family did not require further intervention from ACS and the case was determined and closed timely.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062054 - Deceased Child, Male, 3 Yrs	062055 - Mother, Female, 30 Year(s)	Lack of Supervision	Substantiated
062054 - Deceased Child, Male, 3 Yrs	062056 - Father, Male, 24 Year(s)	Lack of Supervision	Substantiated
062054 - Deceased Child, Male, 3 Yrs	062055 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated

062054 - Deceased Child, Male, 3 Yrs	062056 - Father, Male, 24 Year(s)	DOA / Fatality	Substantiated
062054 - Deceased Child, Male, 3 Yrs	062055 - Mother, Female, 30 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
062054 - Deceased Child, Male, 3 Yrs	062056 - Father, Male, 24 Year(s)	Inadequate Food / Clothing / Shelter	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?	☒	☐	☐	☐
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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were referred for bereavement services and burial assistance.

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? No

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)
11/13/2021	Deceased Child, Male, 2 Years	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
An SCR report alleged on 11/12/21, around 8:15 PM, the mother went with 2 individuals to the father's home. The mother and the individuals forcefully entered the home while the child was present. The mother proceeded to break a bedroom door trying to get the child. The child did not sustain injuries. The father sustained a scratch to his neck.

Report Determination: Indicated **Date of Determination:** 02/01/2022

Basis for Determination:
ACS documented that the investigation revealed credible evidence that the mother went into the father's home while the child was asleep. The mother and the individuals assaulted the father and caused damage to the bedroom door in an attempt to take the child from the father's home. The mother was arrested for endangering the welfare of a child. An order of protection was granted against the mother with regard to the father.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check was documented. Home visits were made. The parents and collateral contacts were interviewed. The Safety Assessments were completed inaccurately, and the investigation was closed with the Safety Assessment reflecting a Safety Decision #3.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
Although the documentation included facts from the case, the child was not in immediate or impending danger at the time the Safety Assessment was completed; therefore, the Safety Assessment completed at the time of determination was inaccurate. The Safety Assessment was completed with regard to risk.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/24/2020	Deceased Child, Male, 1 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Male, 1 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 1 Years	Father, Male, 22 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Male, 1 Years	Father, Male, 22 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the father had severe anger, untreated mental health concerns, and became extremely physically violent toward the mother on a consistent basis. The physical violence occurred in the presence of the child, who the

father also slapped. There was no indication that the child was ever physically harmed during the incidents of physical violence between the adults. The mother suffered from postpartum depression and cried on a daily basis. The parents did not provide adequate care to the child. The parents did not provide the child with adequate food, and he was malnourished. The child was left in soiled diapers, resulting in severe diaper rashes.

Report Determination: Unfounded | **Date of Determination:** 05/15/2020

Basis for Determination:
The investigation did not reveal credible evidence to support the allegations. ACS documented observing the parents "capability to apply the overall quality of care for the subject child." The Investigation Conclusion Narrative stated the parents had "adequate means to ensure ample provisions of food, clothing and shelter."

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check was documented. Home visits were made, and the parents were interviewed. Collateral contacts were made. The Safety Assessments were completed inaccurately. Written notice was provided timely.

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

Issue:
Adequacy of Documentation of Safety Assessments

Summary:
Although the Safety Assessments were completed timely, they were completed with regard to risk regarding the child, not the child's immediate or impending safety. As a result of the inaccurate Safety Assessments, the case was closed with a Safety Decision #3.

Legal Reference:
18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:
The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

[redacted]

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 New York.

Preventive Services History

1/12/22- 2/1/22 A Preventive Service Case was opened immediately following a CPS investigation. The Safety Assessment that was completed at the time of determination documented a Safety Decision #3, which would result in an open service case; however, casework counseling services were not provided to the family. The case was closed after the father was provided with a daycare voucher.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: Unknown	**To:** Unknown
Explain: There was a stay-away order of protection against the mother on behalf of the father obtained in November 2021. The order of protection remained in effect at the time the mother was residing in the home, and at the time of the child's death.	

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