Child Fatality Report

Report Identification Number: BU-22-010

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

Issue Date: Nov 21, 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: Erie
Gender: Male
Date of Death: 06/16/2022
Initial Date OCFS Notified: 06/16/2022

Presenting Information

Erie County Department of Social Services (ECDSS) received three SCR reports on 6/16/22, that alleged the mother left the 3-year-old subject child unsupervised in the living room while she went to the bathroom. The subject child climbed on top of a dog crate that was located under an open window with a screen. The subject child pushed on the screen and fell four stories to the ground. A bystander called 911; law enforcement and emergency services responded, began life saving measures and transported the subject child to the hospital, where he was pronounced deceased. The roles of the father and the surviving sibling were unknown.

Executive Summary

This fatality report concerns the death of a 3-year-old male subject child that occurred on 6/12/22. At the time of the subject child's death, he resided with his mother, 5-year-old surviving sibling, and maternal uncle, in the maternal uncle's apartment. At the time of the fatal incident, the child was at home with his mother. The maternal uncle was not home at the time of the fatal incident, he was staying at his girlfriend's and the surviving sibling was at the maternal great grandmother's apartment. The father was not residing in the home at the time of the fatal incident but had regular contact with the children. ECDSS observed the surviving sibling at the MGGM's residence, and the home was assessed to be safe with no safety hazards. ECDSS transported the mother and the surviving sibling to the pediatrician and the sibling had a medical evaluation, no concerns were found.

The investigation revealed that the family had been residing with the maternal uncle, in the same apartment building since March, because of a fire in the mother's apartment that caused damage and it had not been repaired. The mother reported the day of the incident the subject child followed her into the bedroom to plug her cellphone into a charger and then she went to use the bathroom and run a bath for the child. The mother reported the subject child was left unsupervised for about two minutes and he climbed on top of the dog crate that was underneath an open window, pushed on the screen and fell four stories to the ground. The mother ran down the stairs and outside where the subject child was lying on the ground. A bystander called 911 and first responders arrived on the scene and began life saving measures on the subject child. Emergency Medical Services transported the subject child to the hospital where he was pronounced deceased. Law enforcement confirmed there was a screen found on the ground near the subject child at the time of the fatal incident.

ECDSS contacted the medical examiner, and learned an autopsy was performed. The autopsy findings were consistent with the subject child falling out of a four-story window. The manner of death was accidental, and the cause of death was blunt force injuries to the head and chest. The toxicology report "did not identify the presence of controlled drugs or chemicals". Law enforcement investigated the incident, and no criminal charges had been filed at the writing of this report.

ECDSS offered grief counseling, domestic violence counseling, housing assistance, and burial assistance to the mother, and she declined all services. ECDSS mailed information regarding grief counseling to the maternal uncle. ECDSS unsubstantiated the allegations of DOA/Fatality, Lack of Supervision, Lacerations, Bruises and Welts, and Inadequate Guardianship against the mother regarding the subject child; however, there was a fair preponderance of the evidence to substantiate the allegations. The subject child was a toddler and required a higher level of supervision. The mother was aware the child was able to climb on objects, and often did so. The placement of the dog crate was under an open window that had a screen, but no safety gate, which posed an imminent danger to the child given his physical ability and history of climbing on objects.

PIP Requirement

ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the ECDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ECDSS 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:**
  - **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?** No

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:

Although all other work was commensurate with the casework activity, the determination was not.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	There was a fair preponderance of evidence gathered during the investigation to support substantiating the allegations and indicating the report.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ECDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the (whichever) Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/16/2022 **Time of Death:** 08:19 PM

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 07:42 PM
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
- ☒ Playing
- ☐ Other
- ☐ Working
- ☐ Eating
- ☐ Driving / Vehicle occupant
- ☐ Unknown

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	No Role	Male	28 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Other Household 1	Father	No Role	Male	28 Year(s)

LDSS Response

ECDSS investigated the subject child's death by reviewing SCR history, notifying the DA's office of the child's death, and speaking to the sources of the reports, the pediatrician, school staff, first responders and law enforcement.

ECDSS interviewed the mother at the MGGM's residence on 6/16/22, and again at the MU's residence, on 6/17/22. The mother reported the SC followed her when she went into the bedroom to plug her cellphone into a charger, she then went into the bathroom, urinated, and started the water for the SC to take a bath. At the 6/17/22 home visit the dog crate was observed under the window from which the subject child fell. The crate was approximately two feet high and was a few inches away from the window. The mother reported she would have to place chairs on top of the table so the subject child could not climb on them, ECDSS did observe a chair on top of the table during the home visit. The mother denied ever seeing the subject child climb on top of the dog crate. ECDSS observed a dent in the top of the dog crate, the mother reported the dent was from her sitting on the dog crate and watching the surviving sibling from the window, while the surviving sibling was outside at school during recess. The mother stated to ECDSS that this would have never happened if

she was in her own apartment; however, the record did not reflect further information was gathered regarding what the mother meant. ECDSS observed the window in the apartment to be halfway open, the mother reported that was the window with the screen and the other window was never opened because there was no screen.

The mother reported she had been staying at the MU's apartment for about 3 months because there was a fire in her apartment and the repairs had not been completed. The mother said she accidentally left the stove on and there was a pan of grease on top of the stove. The MU reported the mother did not turn the stove knob off all the way and the stove was left on. The MU also stated the screen in the window had always been loose and nothing was ever repaired in the apartment building. The mother made ECDSS aware that she and the MGGM, the MGM and MU all resided in the same building and it that is why she stayed with the MU while her apartment was being repaired. The SS was not home at the time of the fatal incident and was with the MGGM.

The father was interviewed at the MGGM residence and stated he was not residing in the home, was not in the apartment when the fatal incident occurred and was unaware of how the incident happened. The father refused the SS to be interviewed by ECDSS and the mother declined to go against the father not allowing the SS to be interviewed. The MGGM was interviewed and had no concerns for the mother, SC, or the SS.

ECDSS reviewed records and spoke with the pediatrician regarding the SC and SS; there were no concerns for either child. ECDSS spoke with the speech therapist the SC saw twice per week. The therapist reported no concerns for the mother's care of the child but did report the SC climbing on things at the office and that the SC had a poor understanding of rules or fear.

Law Enforcement incident reports were obtained by ECDSS and revealed a history of the father being physically and verbally aggressive toward the mother from 5/2020-11/2020. There was no history of any orders of protection.

At the close of the investigation the mother and the SS were residing with the MGGM. The MU was mailed grief counseling information and it was unknown if the MU engaged in services.

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)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060761 - Deceased Child, Male, 3 Yrs	060792 - Mother, Female, 25 Year(s)	DOA / Fatality	Unsubstantiated
060761 - Deceased Child, Male, 3 Yrs	060792 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Unsubstantiated

060761 - Deceased Child, Male, 3 Yrs	060792 - Mother, Female, 25 Year(s)	Lack of Supervision	Unsubstantiated
060761 - Deceased Child, Male, 3 Yrs	060792 - Mother, Female, 25 Year(s)	Lacerations / Bruises / Welts	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?	☒	☐	☐	☐

Additional information:
The father would not allow the SS to be interviewed face to face.

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	☐	☐	☐	☐	☐	☒	☐

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? Yes
Explain:
ESDSS offered services and the mother declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ECDSS offered services and the mother declined.

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? No
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)
05/02/2020	Deceased Child, Male, 1 Years	Father, Male, 26 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
ECDSS received an SCR report on 5/2/20, that alleged the father and the mother engaged in a verbal argument that escalated in the presence of the SC. The father punched the mother on the left side of the face while the SC was in a playpen in the same room. The SC did not sustain any injuries. The role of the mother and the SS were unknown.

Report Determination: Indicated | **Date of Determination:** 06/01/2020

Basis for Determination:
Through home visits, interviews, and collateral contacts ECDSS learned there was a verbal dispute that turned physical between the mother and the father. The mother confirmed she was hit in the presence of the SC, which placed the child at risk of harm. There was a history of CPS reports and incident reports from law enforcement regarding domestic violence between the parents. A domestic violence referral was made, and the mother refused services. The allegations of Inadequate Guardianship against the father, regarding the SC was substantiated and the case was closed.

OCFS Review Results:
ECDSS checked history, made home visits, conducted interviews, and assessed the safety of the children. Notification letters were mailed, and progress notes were entered in a timely manner. ECDSS did not follow up with the mother regarding the incident reports received from LE regarding DV incidents following the initial report. ECDSS did not consult with the legal department regarding the history of the DV and the father's return to the home several days after the CPS report despite the mother stating she would keep the father away from the home and use a third party for visitation.

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

Issue:
Assessment as to need for Family Court Action

Summary:
There was significant history of verbal and physical violence toward the mother by the father, placing the children at risk of harm. Police reports obtained by ECDSS revealed there were 3 more DV calls to the mother's home within 5 days of receiving the report and the mother had agreed to not allow the father back in the home.

Legal Reference:
SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:
ECDSS shall, in all cases where a child abuse or maltreatment report is being investigated, assess whether the best interests of the child require Family Court or Criminal Court action and shall initiate such action, whenever necessary.

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

In 2019, the mother and father were named subjects in an unfounded investigation with allegations of IG regarding the SC and the SS.

Known CPS History Outside of NYS

There was no 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.

Additional Local District Comments

ECDSS respectfully disagrees that there was a fair preponderance of evidence to support indicating the fatality investigation. While we may have been able to indicate under the old standard of some credible evidence, several factors led us to find there was not a fair preponderance of evidence in this investigation. First, despite the child being a climber, all adults living in the home reported that the child had never climbed on the dog crate. Also, the mother showed a concern for safety in that she did not open the part of the window that had no screen. Finally, the child was outside of the mother's line of vision for no more than two minutes and was in the very next room, with no prior indication that the child would climb on the crate. The required action states that ECDSS will refer to the CPS Program Manual when determining allegations and will consult with the OCFS Regional Office if guidance is needed. During the course of the 45-day review conducted with OCFS, OCFS advised ECDSS to consult the Program Manual and to clearly document the reasoning for the determination decision. This review of the manual was completed and is reflected in the Investigation Conclusion narrative, which includes a detailed description of how the worker arrived at her decision. If OCFS was of the opinion that a fair preponderance of evidence existed to indicate the report, we would have hoped that OCFS would have voiced said opinion during the 45-day review. As to the historical CPS investigation dated 5/2/20, we must unfortunately concur with the reviewer's citation. A review of that investigation shows that, given the extensive history of law enforcement involvement, a prior CPS report of domestic violence, and a historical lack of cooperation, there should have been an assessment of the need for Family Court action. As a corrective action, this issue will be addressed as an agenda item during a scheduled CPS Team Leader meeting and further disseminated to investigative staff.

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