NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: RO-16-007 **Prepared by: Rochester Regional Office**

Issue Date: 12/20/2016

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: 2 year(s)
Jurisdiction: Wayne
Gender: Female
Date of Death: 06/04/2016
Initial Date OCFS Notified: 06/04/2016

Presenting Information

On 06/04/16, Wayne County Department of Social Services (WCDSS) received an initial and 2 subsequent reports from the State Central Register (SCR) regarding the family of the subject child (SC). The report alleged that the SC was found by an unknown person unresponsive in the family pool. Emergency Medical Services (EMS) responded to a 911 call and found the SC in cardiac arrest. The SC was transported to the local hospital where she was pronounced dead. The presumed cause of death is drowning. The SC had no visible injuries and was an otherwise healthy child. The BM, BF and maternal grandparents were present and considered responsible for the death of the SC.

Executive Summary

This fatality report concerns the death of a 2-year-old female that occurred on 06/04/16. WCDSS received an initial and 2 subsequent reports from the SCR regarding to the SC with allegations of Dead on Arrival/Fatality (DOA), Inadequate Guardianship (IG) and Lack of Supervision (LOS).

WCDSS initiated the investigation timely and completed adequate safety/risk assessments. In addition, WCDSS conducted an adequate investigation and assessment of service needs.

The report was indicated against the BM, BF, MGM, and PGF as some credible evidence was found to support all allegations and all three elements of maltreatment. It was determined that all 4 individuals were legally responsible for the SC and failed to provide a minimum degree of care for her as they did not assure that the SC had proper supervision. Parents and other persons legally responsible have a responsibility to supervise their children or arrange for proper competent supervision. The BM, BF and maternal grandparents failed to consider the development/age of the SC and the environmental factor of the pool which elevated the level of required supervision. As a result, the SC was able to access the pool without any of the adults being aware.

As per the Coroner's report dated 6/30/16, the manner of death was listed as drowning with acute pulmonary and cerebral edema. The cause of death was listed as accidental drowning. The lack of supervision was a direct cause of the SC's death.

There are no required actions needed.

There is 1 recommendation. The RRO recommends that WCDSS re-review 06-OCFS-ADM-08 - CPS Investigations with Multi-Disciplinary Teams/Law Enforcement, Chapter 494 of the Laws of 2006 and all established protocols pertaining to joint investigations of child fatalities, serious injuries, and sex abuse allegations with all local and state law enforcement agencies within the county.

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

Explain:
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: 06/04/2016 **Time of Death:** 04:10 PM

Time of fatal incident, if different than time of death: 03:15 PM

County where fatality incident occurred: WAYNE
Was 911 or local emergency number called? Yes
Time of Call: 03:22 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? No - but needed
At time of incident supervisor was: Unknown if they were impaired.

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	No Role	Female	14 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	43 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

LDSS Response

On 06/04/16, WCDSS responded to the fatality by contacting the local hospital. It was reported that the cause of death was drowning and that the SC was pronounced dead at 4:10pm. WCDSS also conducted a home visit at the case address. During the home visit, the WCDSS worker observed the pool being drained and dismantled. WCDSS made contact with all family members and conducted several home visits at the case address during the course of the investigation. WCDSS was unable to conduct joint interviews with law enforcement due to the fact that the responding NYS police investigator obtained written statements immediately after the incident. The statements were all completed and signed between 4 and 5:30 p.m. WCDSS did not receive the initial report from the SCR until 6:36 p.m.

It was determined that on the day of the incident, the SC woke up from a nap at about 2:45p.m. The BF dressed the SC in swimming gear and took her outside. Upon arriving outside, the surviving sibling, maternal grandmother and aunt of the SC were all exiting the pool. As a result, the SC was unable to enter the pool. According to the MGM she locked the gate to the pool; the BF also reported that he observed her locking the gate. The SC then went to the back yard to a play area with the 4-year-old surviving sibling; the BM confirmed observing the SC in the play area at about 3:15 p.m. The BM and BF were cleaning their camper in preparation for an upcoming trip. The maternal grandparents were in another location of the yard sitting and talking to a neighbor. After about 5 minutes, the BM asked where the SC was as she no longer saw her in the play area. No one was aware so they all started looking for the SC. The MGM found the SC at the bottom of the pool. The MGM and BF both jumped in and pulled her out. The MGF called 911 at 3:22 p.m. while the BF started CPR. The family admitted that the pool did not have an alarm as they had remove it and denied being aware of how the SC was able to access the pool.

On 6/6/16, WCDSS contacted the District Attorney's office and the DSS attorney to discuss the details related to the case. At the time, it was determined that criminal charges would not be filed and family court intervention was not appropriate. On the same day, WCDSS received a copy of the hospital ED records. According to the hospital records, the SC was in cardiac arrest for about 7 minutes. There were no signs of trauma to the SC's body.

On 6/7/15, WCDSS interviewed the first responder from the fire dept. The first responder reported that upon arriving at the case address the SC had been removed from the pool and was lying on the deck. He The SC was cold to touch and her pupils were not moving. The first responder believed that the SC was deceased however resuscitation efforts continued until the SC was transported to the hospital. On 6/8/16, WCDSS interviewed the responding investigator from NYS police. The investigator reported that there was nothing out of the ordinary when he responded to the home. He further reported that no one appeared to be intoxicated or under the influence of any substances. According to the investigator, the family was not in compliance with town code due to the fact that the pool did not have an alarm. Between 6/8/16 and 6/30/16, WCDSS continued to conduct investigative activities to assure the safety and wellbeing of all family members.

On 6/30/16, WCDSS received the final autopsy report. As per the Coroner, the manner of death was listed as drowning with acute pulmonary and cerebral edema. The cause of death was listed as accidental drowning.

On 7/27/16, WCDSS substantiated all three allegations against the BM, BF, and maternal grandparents citing that they were all legally responsible for the SC and failed to provide a minimum degree of care thus causing the death of the SC.

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: Coroner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?No
Comments: WCDSS was unable to conduct joint interviews with law enforcement due to the fact that the responding NYS police investigator obtained statements from each individual that was present when the incident occurred immediately after the incident. The supporting depositions were all completed and signed between 4 and 5:30 p.m. WCDSS did not receive the initial report from the SCR until 6:36 p.m.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
032481 - Deceased Child, Female, 2 Yrs	032484 - Mother, Female, 25 Year(s)	Lack of Supervision	Substantiated
032481 - Deceased Child, Female, 2	032484 - Mother, Female, 25 Year(s)	DOA / Fatality	Substantiated

Yrs			
032481 - Deceased Child, Female, 2 Yrs	032487 - Grandparent, Female, 43 Year(s)	Inadequate Guardianship	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032487 - Grandparent, Female, 43 Year(s)	Lack of Supervision	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032487 - Grandparent, Female, 43 Year(s)	DOA / Fatality	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032485 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032485 - Father, Male, 28 Year(s)	Lack of Supervision	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032485 - Father, Male, 28 Year(s)	DOA / Fatality	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032484 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032486 - Grandparent, Male, 43 Year(s)	Lack of Supervision	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032486 - Grandparent, Male, 43 Year(s)	Inadequate Guardianship	Substantiated
032481 - Deceased Child, Female, 2 Yrs	032486 - Grandparent, Male, 43 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☐	☒	☐	☐
Was there timely entry of progress notes and other required	☒	☐	☐	☐

documentation?				

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate 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?	☐	☐	☒	☐

Explain:
WCDSS conducted on-going safety assessments to assure the safety of the surviving sibling and teenage aunt of the subject child however, they did not document the completion of a 7-day safety assessment in connections.

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	☐	☐	☐	☐	☐	☒	☐

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:
WCDSS referred all family members to bereavement counseling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS referred all family members to bereavement counseling.

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

No CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

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

Action:	The investigation regarding the SC's death was not investigated jointly between WCDSS and law enforcement. The responding Law enforcement agency started their investigation without contacting the SCR or notifying WCDSS of the fatality. As a result, the RRO recommends that WCDSS re-review 06-OCFS-ADM-08 - CPS Investigations with Multi-Disciplinary Teams/Law Enforcement, Chapter 494 of the Laws of 2006 and all established protocols pertaining to joint investigations of child fatalities, serious injuries, and sex abuse allegations with all local and state law enforcement agencies within the county.

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