NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: RO-16-002 **Prepared by: Rochester Regional Office**

Issue Date: 7/20/2016

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
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		

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Yates
Gender: Female
Date of Death: 02/01/2016
Initial Date OCFS Notified: 02/01/2016

Presenting Information

On 02/01/16, Yates County Department of Social Services (YCDSS) received an initial report from the State Central Register (SCR) regarding the family of the subject child (SC). The report alleged that the BM allowed the 2-year-old SC to play outside while she was inside the home watching through the window. At some point, the BM turned away from the window to start cooking dinner. As a result, the BM lost sight of the SC for at least 5 minutes. When the BM looked out the window after about 5 minutes, she saw the SC floating in a pond. The SC had fallen in a pond located about 15 feet from the house. Emergency services were called at 4:54 PM. The SC was transported to the hospital and pronounced deceased. The BF was not at the home when the incident occurred.

Executive Summary

This fatality report concerns the death of a 2-year-old female that occurred on 02/01/15. YCDSS received an initial SCR report regarding the death on the same date with allegations of Dead on Arrival/Fatality (DOA), Inadequate Guardianship (IG) and Lack of Supervision (LOS). YCDSS received a subsequent report from the SCR on 02/02/16 with the same allegations. The BM and BF were listed as the subjects of the report. YCDSS initiated the investigation in a timely manner and conducted a joint investigation with Law Enforcement (LE). YCDSS conducted a very thorough investigation and assessment of service needs.

The death certificate lists the immediate cause of death as Cardiopulmonary Arrest due to a drowning. The family refused an autopsy.

There are no corrective or recommended actions.

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?** 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:
As noted above.

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:
As noted above.

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: 02/01/2016 **Time of Death:** 05:58 PM

Time of fatal incident, if different than time of death: 04:53 PM

County where fatality incident occurred:	YATES
Was 911 or local emergency number called?	Yes
Time of Call:	04:53 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	Deceased Child	Alleged Victim	Female	2 Year(s)

Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	25 Year(s)

LDSS Response

YCDSS responded to the SCR report by conducting a collateral contact with LE on 02/01/16 and 02/02/16. LE confirmed the death of the SC and provided the current status of the case. LE provided YCDSS with photographs of the scene and confirmed that there were no surviving siblings or other children in the home. LE also informed YCDSS that the details of the incident would be reviewed with the District Attorney's office to determine whether or not criminal charges would be filed against the BM.

On 02/02/16, YCDSS conducted a joint home visit with LE to interview the BM and BF. It was determined that on the day of the incident the BF was not at the home as he was at work. The SC was in the sole care of the BM. The BM reported that she took the SC outside at about 4:30p.m. She sat on the front porch while the SC played. The BM reported that the SC wanted to play with chickens that were located in a green house on the property. The BM allowed the SC to do this while she went inside the home. The BM sat in a rocking chair inside the home reading a book while the SC played outside. The BM was able to see the SC through a window. At some point, the BM left the area to start dinner, leaving the child without visual supervision for about 10 minutes. When she went back to the window to check on the SC, she observed something pink floating in the pond. The BM realized that the SC was wearing a pink jacket. The BM then ran outside and pulled the SC out of the pond and called 911 for assistance at 4:53 PM. The pond is located about 15 feet from the home. The BM reported that she was instructed to take the SC inside the home. The BM placed the SC in front of the fireplace. The local Sheriff's department and EMS arrived at 4:55 PM.

On 02/08/16, YCDSS received and reviewed the records from the attending hospital. The records noted that when EMS arrived, the SC's body temperature was 73 degrees and it was estimated that she was in the pond for about 10 minutes. After several attempts to warm the SC's body up, her temperature did not rise above 83 degrees. The hospital was unable to transport the SC to another hospital for further treatment as her body temperature did not reach at least 92 degrees. The SC was pronounced dead at 5:58 PM.

YCDSS contacted first responders on 02/09/16 & 02/10/16. It was reported that upon arrival the SC was in the home and observed to be dark in color and not breathing. During chest compressions, there was a constant flow of water and vomit. After chest compressions, the SC's color did improve. It was further reported that the pond was frozen except for a small hole. In addition, the SC's footprints were observed around the pond. The SC was transported to the local hospital for further treatment.

On 02/09/16, YCDSS followed with the local district attorney's office to check the status of criminal charges.
On 02/18/16, YCDSS received a copy of the death certificate. The immediate cause of death was listed as cardiopulmonary arrest due to drowning. The parents refused an autopsy. Between the end of February and the beginning of April, YCDSS continued to conduct appropriate investigative activities.

On 04/01/16, YCDSS appropriately indicated the report as all allegations were substantiated against the BM. The allegations were unsubstantiated against the BF. YCDSS documented that on the date of the incident the BM allowed the SC to play outside unsupervised while she was inside the home supervising the SC by looking through a window. The BM admitted to walking away from the window, into another room. The SC was left without supervision for about 10 minutes. Some credible evidence was found to support that the BM failed to exercise a minimum degree of care by leaving the SC

outside, unsupervised near an open pond, subsequently causing the death of the SC. To date, criminal charges have not been filed against the BM.

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: YCDSS conducted a joint investigation with law enforcement as per approved protocols.

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
029302 - Deceased Child, Female, 2 Yrs	029303 - Mother, Female, 25 Year(s)	DOA / Fatality	Substantiated
029302 - Deceased Child, Female, 2 Yrs	029304 - Father, Male, 24 Year(s)	DOA / Fatality	Unsubstantiated
029302 - Deceased Child, Female, 2 Yrs	029303 - Mother, Female, 25 Year(s)	Inadequate Guardianship	Substantiated
029302 - Deceased Child, Female, 2 Yrs	029303 - Mother, Female, 25 Year(s)	Lack of Supervision	Substantiated
029302 - Deceased Child, Female, 2 Yrs	029304 - Father, Male, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
029302 - Deceased Child, Female, 2 Yrs	029304 - Father, Male, 24 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐
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?	☐	☒	☐	☐

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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was referred to a community agency for grief and loss 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 within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

No known CPS history outside of NYS.

Services Open at the Time of the Fatality

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.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement 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