Child Fatality Report

Report Identification Number: SY-17-043

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

Issue Date: Mar 05, 2018

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		
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	
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: 2 year(s)
Jurisdiction: St. Lawrence
Gender: Male
Date of Death: 09/06/2017
Initial Date OCFS Notified: 09/06/2017

Presenting Information

On 09/06/17, an SCR report was received alleging that on 9/05/17, the 2-year-old SC was in the care of the guardian and went missing. As a result, the child was later found face down in a creek.

On 09/06/17, the SCR received a second report, alleging that on 09/05/17, the SM was vacuuming her car outside, while the SC was in an enclosed porch of their home. After an undetermined amount of time, the SM realized that the SC was gone from the porch and began to look for the SC. After 30 to 40 minutes, the SM engaged neighbors to help search. After searching for close to an hour, neighbors called police.

When found, the child's body was extremely cold due to his body being immersed in the water for a long time. The SC succumbed to his injuries on 09/06/17.

Executive Summary

Within 24-hours, SLCDSS began their investigation by meeting with LE, contacted medical personnel, and conducted a visit to the home. SLCDSS coordinated their investigation with LE through interviews with family members, medical staff, EMS, and neighbors. During the investigation, SLCDSS learned that on 09/05/17, the SC was in the care of SM, who was outside cleaning an automobile, while the SC was unattended in the family's home.

The BF was residing in Onondaga County and was not present at the time of the incident. SLCDSS adequately assessed safety within 24-hours by determining there were no surviving siblings in the home. They contacted Florida CPS, where the family previously resided, to determine if there was any CPS history in that state. Despite diligent efforts to gather this information, it was not obtained as requested by SLCDSS. CPS history in NY was reviewed.

SLCDSS entered progress notes contemporaneously and all allegations were addressed with the SM. SLCDSS was timely in sending the Notice of Existence (NOE) letters to all subjects of the report. SLCDSS completed the 24-hour safety assessment, the 7-day safety assessment, and the Risk Assessment Profile timely and accurately.

SLCDSS spoke with multiple collaterals that stated that SM always supervised the SC. SLCDSS unsubstantiated the allegations against the SM of LS, IG, and DOA based on their conclusion that this was an isolated incident. OCFS is not in agreement with this determination. During the investigation it was learned by SLCDSS that the SC was an active child who required constant supervision. Although the evidence gathered suggested that the SM did not intentionally cause the SC death, she did not provide appropriate supervision to the SC on the day of the fatal incident.

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?** No

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:
OCFS does not agree with the determination as there was some credible evidence to indicate LS and IG. The SM did not exercise reasonable and prudent parenting.

Required Actions Related to the Fatality

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

Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-day Fatality Report was not completed on time. The Fatality Report was due on 10/06/17 and was completed on 10/23/17.
Legal Reference:	CPS Program Manual, VIII, B.2, p.4
Action:	SLCDSS will complete the 30-Day Fatality Report within the required 30 days when investigating allegations of the death of a child as a result of abuse or maltreatment.
Issue:	Appropriateness of allegation determination
Summary:	The SM failed to provide competent supervision for the period of time that she left the SC alone in the house while she was outside. As a result, the SC wandered off to a nearby stream and drowned.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	Before making a determination, SLCDSS will review the legal definitions of allegations found in the CPS Manual.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/06/2017 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 09/05/2017

Time of fatal incident, if different than time of death: 01:00 PM

County where fatality incident occurred: St. Lawrence
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 30 Minutes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☒ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☐ Asleep
- ☐ Impaired by illness
- ☐ 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	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	42 Year(s)
Deceased Child's Household	Other - Step Grandfather	No Role	Male	67 Year(s)
Deceased Child's Household	Sibling	No Role	Male	20 Year(s)
Other Household 1	Father	No Role	Male	47 Year(s)

LDSS Response

Two SCR reports were made on 9/6/17 alleging IG, LS, and DOA/Fatality regarding the fatality of the SC. SLCDSS began an investigation within 24 hours after receiving the SCR report. SLCDSS contacted the collaterals, the ER, LE, and the coroner. SLCDSS was assigned primary jurisdiction of the investigation, while OCDSS was assigned secondary jurisdiction because, SC was hospitalized in Onondaga County.

During the investigation, SLCDSS learned that on 9/6/17, SM left the 2-year-old SC in the home watching a movie in their bedroom, when she went outside to vacuum an automobile. The SM was aware that the adult-sibling (AS) in the home was sleeping during the time the SM was outside. The SM said she latched the door when she left the home and checked on the SC approximately every 5 minutes for approximately 20 minutes. The SM ran the vacuum cord out of the porch door and

did not latch it. When the SM finished vacuuming the automobile, the SM went inside of the home and discovered the SC missing. The SC did not have a history of leaving the home. The SM began searching for the SC in and around the home, but could not find him. The SM engaged neighbors and the AS to help search. The step-grandfather came home from work during the search of the SC and helped search. After approximately 30 minutes of unsuccessful searching, the SM called 911, not the neighbor as was previously reported. Soon after the 911 call, a neighbor found the SC face down and unconscious in a stream near the home. According to step-grandfather, the SC had no history of being near the stream or having awareness of it prior to that day. Two neighbors began CPR, in an attempt to resuscitate the SC. While CPR was being administered, LE and EMS arrived at the scene and took over resuscitation efforts. The SC was taken to a St. Lawrence County hospital and was later airlifted to a hospital in Onondaga County. The child was placed on life support, but was later taken off and declared deceased on 9/6/17.

SLCDSS coordinated their investigation with LE and conducted joint interviews throughout the investigation. SLCDSS established contact with the family, EMS, coroner, Florida CPS, medical personnel, and collaterals during the investigation. SLCDSS adequately conducted a safety assessment of the home within 24-hours and determined that there were no SS or other children residing in the home. SLCDSS completed the 30-day fatality report, but did not do so until 17 days after it was due.

SLCDSS learned that the SC was born in Florida, where SM and BF had resided for approximately 3 years, before moving back to NYS in 2017. SLCDSS made multiple requests for information to Florida CPS to determine if the family had CPS involvement while residing in Florida. Although diligent efforts were made, no information was received from Florida.

The BF lives in Onondaga County and was not present at the time of the incident. The BF was notified of the death and interviewed by SLCDSS. He had previously expressed concerns to the BM that she needed to be vigilant in supervising the SC, because the SC was a very busy child and all over the place.

The initial and subsequent report were closed and UNF, despite the fact that SLCDSS had gathered some credible evidence to substantiate allegations against SM. During the investigation, SLCDSS learned the SM was aware the SC was an active child who required constant supervision. The SM was also aware there was no adult actively supervising the SC during her temporary absence, while she was preoccupied outside the home. The SC was in the home unattended for approximately 20 minutes, while the SM was outside. As a result of the lack of supervision, the SC was able to leave the home without the SM's knowledge and drowned as a result.

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 reviewed by an OCFS approved Child Fatality Review Team?No
Comments: No approved CFRT in St. Lawrence county.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

042121 - Deceased Child, Male, 2 Yrs	043022 - Mother, Female, 42 Year(s)	Lack of Supervision	Unsubstantiated
042121 - Deceased Child, Male, 2 Yrs	043022 - Mother, Female, 42 Year(s)	DOA / Fatality	Unsubstantiated
042121 - Deceased Child, Male, 2 Yrs	043022 - Mother, Female, 42 Year(s)	Inadequate Guardianship	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 30-day fatality report was completed 17 days late.

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	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The SM had an untreated medical condition and may have benefited from a referral to health care services.

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? 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)	Status/Outcome	Compliance Issue(s)

09/06/2017	Deceased Child, Male, 2 Years	Mother, Female, 42 Years	Lack of Supervision	Unfounded	Yes
	Deceased Child, Male, 2 Years	Mother, Female, 42 Years	Inadequate Guardianship	Unfounded	

Report Summary:
The SCR report alleged that the LS by the SM led to the fatal incident. The investigation was done concurrently with the fatality investigation.

Determination: Unfounded **Date of Determination:** 01/08/2018

Basis for Determination:
After interviewing the BF, SM, LE, and several other collaterals, SLCDSS found their was no credible evidence that the SM leaving the child unattended on the day of the incident led to his death. SLCDSS documented that the SM actions were appropriate when she realized the SC was missing. They further determined that there was no evidence that the SC was left unattended for lengthy period of time. SLCDSS determined the SM actions, nor inactions, led to the death of the child.

OCFS Review Results:
SLCDSS coordinated their investigation with LE. SLCDSS contacted appropriate collaterals. SLCDSS also diligently tried to obtain from Florida CPS. OCFS is not in agreement with the determination based on the case record. there was some credible evidence in the case record based on interviews with the BF that the SC was very active and needed constant supervision.

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

Issue:
Appropriateness of allegation determination

Summary:
SLCDSS inappropriately unsubstantiated LS and IG against the SM. There was some credible evidence that the SC required constant supervision. It was not reasonable for the SM to leave the SC unsupervised for any period of time given his age.

Legal Reference:
FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:
SLCDSS will refer to the CPS Program Manual and/or consult with the Syracuse Regional Office when determining the appropriateness of allegations, and will take into consideration all information when applying the circumstances to the definition(s).

[redacted]

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

On 4/27/11 a SCR report was registered against the SM for IG and IF/C/S of the SC sibling. On 7/18/11, the report was unfounded.

On 12/10/10, an SCR report was registered against the SM for IG, IF/C/S, and LMC of the SC sibling. On 2/8/11, the report was unfounded.

On 4/20/2010, an SCR report was registered against the SM for IG of the SC sibling. On 7/20/10, the report was indicated for IG.

On 5/20/09, an SCR report was registered against the SM for IG and LS of the SC sibling. On 6/23/09, the report was unfounded.

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