Child Fatality Report

Report Identification Number: SY-22-018

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

Issue Date: Sep 12, 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		
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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 7 year(s)
Jurisdiction: Jefferson
Gender: Female
Date of Death: 04/22/2022
Initial Date OCFS Notified: 04/23/2022

Presenting Information

Jefferson County Department of Social Services received an SCR report that alleged the subject child was autistic, non-verbal and required a higher level of supervision and support in terms of toileting and general safety. On 4/22/22, the father failed to supervise the subject child for at least half an hour. As a result, the subject child left the home and climbed into the swimming pool, where she drowned. The pool was above ground, that is entered by a wooden deck that had a gate. The wood on the deck was old, aged and the gate was not secured. At approximately 9:30PM, the father discovered the subject child in the swimming pool. The father went into the swimming pool and pulled the subject child out. An unknown adult performed cardiopulmonary resuscitation, and at 9:53PM called 911. Police responded to the home and continued performing cardiopulmonary resuscitation on the subject child. The subject child was transported to the hospital where she was pronounced deceased at 11:32PM.

Executive Summary

This fatality report concerns the death of a 7-year-old female subject child that occurred on 4/22/22. The report contained allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the father. At the time of her death, the subject child resided primarily with her mother; however, she visited her father every other weekend. The 15-year-old sibling resided primarily with the father and visited the mother every weekend. The subject child had autism and was non-verbal.

Jefferson County Department of Social Services (JCDSS) completed collateral and casework contacts and learned that on the evening of 4/22/22, the mother and father met at a mutual location to exchange the children for weekend visitation. The subject child went with the father, while the 15-year-old sibling went with the mother. Around 5:30PM, after arriving home with the subject child, the father provided the subject child with a snack, and she watched TV in her bedroom. The father received a phone call from his girlfriend at 9:33PM and reported being on the phone for approximately 5 to 10 minutes. The father went to the bathroom while still on the phone, and heard that the subject child's TV was paused. When the father went to check on the subject child, he found that she was not in her bedroom. The father searched the inside and outside of the home; however, did not find the subject child. The father's girlfriend suggested the father check the pool. The father found the subject child at the bottom of the pool, jumped in, and pulled her out. The father's phone no longer worked, as it had been submerged in the pool, and therefore the father ran to a neighbor's residence. The neighbor called 911 and performed CPR on the subject child. Emergency medical services responded to the home and continued life-saving measures. The subject child was transported to the hospital, where she was later pronounced deceased.

An autopsy was performed on 4/23/22. The official manner of death was ruled accidental, and the cause was listed as Asphyxiation, secondary to drowning. No criminal charges were pressed related to the subject child's death.

Bereavement services were offered to the family. The mother refused services, and the father stated he was unsure if he wanted to engage in counseling. JCDSS spoke directly to the 15-year-old sibling, who stated he did not want to go to counseling; however, his school confirmed they were providing the sibling with emotional support. The allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the father were substantiated. JCDSS determined there was a fair preponderance of evidence to support that the father failed to meet the minimal degree of care, as he did not provide the subject child with the higher level of supervision she required, resulting in her death. The case was indicated and closed on 6/17/22.

PIP Requirement
For citations identified in historical cases, JCDSS will submit a PIP to the Syracuse Regional Office within 30 days of receipt of this report. The PIP will identify action(s) JCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, JCDSS 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?** Yes

Explain:
JCDSS made an appropriate determination based off the evidence obtained throughout the investigation.

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:
Casework activity was commensurate with the case circumstances.

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: 04/22/2022 **Time of Death:** 11:32 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Jefferson
Was 911 or local emergency number called? Yes
Time of Call: 09:53 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 ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☒ Unknown
☐ Other

Did child have supervision at time of incident leading to death? Yes

At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:
☒ Distracted ☐ Absent
☐ Asleep ☐ 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	Female	7 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	52 Year(s)
Deceased Child's Household	Mother	No Role	Female	39 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)

LDSS Response

Upon receipt of the SCR report, JCDSS coordinated their investigation with law enforcement, conducted a CPS history check, spoke with numerous collaterals, and interviewed the family.

JCDSS interviewed the father regarding the events leading up to the subject child's death. The father reported that on 4/22/22, he met the mother around 4:30PM to exchange the children for weekend visitation. The subject child was spending the weekend with the father, while the 15-year-old sibling was visiting the mother. The father stated that he and the subject child arrived home around 5:30PM. The father changed the subject child's diaper, gave her a snack, and she went into her bedroom to watch TV. The father's friend stopped by the residence around 9:00PM and spoke with the father on the screened in front porch for approximately 15-30 minutes. The father's friend reported to law enforcement that he

did not see the subject child while at the residence; however, did hear the TV on in the home. The father received a phone call from his girlfriend at 9:33PM. The father spoke with his girlfriend for approximately 5-10 minutes, before going to the bathroom. On his way to the bathroom, the father noticed the TV in the subject child's room was paused. The father went into the subject child's room and noticed that she was not there. The father searched inside and outside of the residence; however, was unable to locate the subject child. The father's girlfriend told him to check the pool, which was located in the backyard. When the father looked in the pool, he observed the subject child at the bottom. The father jumped into the pool, pulled the subject child out of the water, and put her on the deck. The father reported that he knew upon pulling the subject child out, that she was deceased. The father ran to a neighbor's residence to call for help, as his phone had been submerged when he jumped into the pool and no longer worked. The father ran into the home, and according to the neighbor, was frantic. The neighbor called 911 and followed the father to the pool. The neighbor performed cardiopulmonary resuscitation on the subject child, while the father went and got blankets to cover her, as he noted she was very cold. The neighbor continued cardiopulmonary resuscitation until emergency medical services arrived, and continued life-saving measures. The subject was transported to the hospital and pronounced deceased at 11:32PM.

The 15-year-old sibling and mother were interviewed, though were not present at the time of the fatality and did not have information to contribute regarding the circumstances. The father's girlfriend confirmed she was on the phone while the father was looking for the subject child and suggested the father look in the pool. The father's girlfriend reported she heard the father screaming "she's dead" and then the line disconnected.

JCDSS learned through the investigation that the subject child had severe autism and was non-verbal. The subject child had anxiety, and was prescribed anti-depressant medication, which were confirmed to be in her system per the Medical Examiner's toxicology report. The subject child got out of the house two years prior but was found in the front yard and the father denied any other instances where the subject child went outside of the home. JCDSS also contacted the code enforcer and learned that the pool did not meet code requirements, as there was no alarm. It was also noted that while the pools gate doors latched, they did not lock and the cover on the pool was observed to be unsecured in the days following the subject child's death.

JCDSS spoke to numerous collateral sources throughout the investigation, and there were no reported concerns regarding the sibling's well-being or safety with the mother or father. The school was providing the sibling with additional emotional support. The sibling was observed on multiple home visits and deemed to be safe in the care of the mother and father.

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
Comments: Jefferson County Department of Social Services referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

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

061161 - Deceased Child, Female, 7 Yrs	061163 - Father, Male, 52 Year(s)	Inadequate Guardianship	Substantiated
061161 - Deceased Child, Female, 7 Yrs	061163 - Father, Male, 52 Year(s)	Lack of Supervision	Substantiated
061161 - Deceased Child, Female, 7 Yrs	061163 - Father, Male, 52 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?	☒	☐	☐	☐
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 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	☒	☐	☐	☐
Explain: Bereavement services were offered to the family; however, refused.				

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:
Bereavement services were offered to the parents on behalf of the 15-year-old sibling. JCDSS spoke directly to the sibling regarding counseling; however, he stated he did not want to engage in services because he did not like to talk. The siblings school reported they were providing the sibling with emotional support.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services and resources were provided to the mother and father. The mother refused services, and the father stated he was not yet sure if he wanted to engage in services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/23/2020	Sibling, Male, 13 Years	Mother, Female, 38 Years	Educational Neglect	Unsubstantiated	Yes
	Sibling, Male, 13 Years	Father, Male, 50 Years	Educational Neglect	Unsubstantiated	

Report Summary:
An SCR report was received on 11/23/20 that alleged the now 15-year-old sibling missed 11 out of 22 school days that year and was failing due to his attendance. The mother and the father had been contacted on several occasions but failed to get the sibling into school. The mother and father reported the sibling hurt his hand but had not provided any medical documentation.

Report Determination: Unfounded | **Date of Determination:** 06/23/2021

Basis for Determination:
JCDSS determined there was no credible evidence to substantiate the allegations. The parents were interviewed and reported that the now 15-year-old sibling had missed school due to an injury. The sibling was interviewed and did not disclose any concerns to CPS. The sibling's attendance improved throughout the investigation.

OCFS Review Results:
JCDSS initiated the investigation in 24 hours, contacted the source of the report, and interviewed all household members, when developmentally appropriate. JCDSS completed the safety and risk assessment timely and adequately. Although the father was interviewed, it was not reflected in the case record that JCDSS made face-to-face contact with him or that an assessment of his home was completed even though the now 15-year-old sibling was residing with the father after the mother and father finalized their divorce. Numerous progress notes were documented more than 30 days late, and there was no casework activity from 11/24/20 to 5/19/21.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
Although the father was interviewed over the phone, the case record did not reflect an attempt to conduct a face-to-face contact with the father or assess his home even though the now 15-year-old sibling was residing with him after the parents finalized their divorce.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
JCDSS will make face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

Issue:
Timely/Adequate Case Recording/Progress Notes

Summary:
There were 7 out of 16 progress notes that were documented more than 30 days late and several months after the event date.

Legal Reference:
18 NYCRR 428.5

Action:
Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

[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 is 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.

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