Child Fatality Report

Report Identification Number: BU-20-011

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

Issue Date: Oct 19, 2020

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: 1 year(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 05/27/2020
Initial Date OCFS Notified: 05/28/2020

Presenting Information

An SCR report alleged on 5/27/2020, the parents were in the back yard with the 1-year-old male subject child, his twin and two other children. The mother went into the home, leaving the father with the children. The two oldest children ran into the garage and the father ran after them, leaving the child and his twin unsupervised. While unsupervised, the child drown in the in-ground pool. The father returned to the twins, with the older children, and began looking for the child. The twin poked at the pool's solar cover and the father pulled the child from the pool. The father ran into the home, holding the child and 911 was contacted. The father performed CPR until EMS arrived and took over resuscitation efforts. The child was transported to the ER, where rescue attempts were continued; however, were unsuccessful. The child was pronounced dead at 8:27 PM. The mother and two older children had unknown roles.

Executive Summary

This fatality report concerns the death of the 1-year-old male subject child that occurred on 5/27/2020. A report was made to the SCR the following day regarding concerns the father was not properly supervising the child and his twin and located the child in the family's inground pool, under the pool cover. The child resided with his parents, twin, and siblings, ages 4 and 5, who were assessed to be safe in the care of their parents.

Niagara County Department of Social Services (NCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. The family had no known criminal history and no CPS history. An autopsy was completed, and the medical examiner listed the cause of death was drowning and the manner of death was accidental.

The parents reported they were outside with the children when the mother went inside. The father was responsible for supervising the children outside. The two older children went into the garage, which was accessible from the backyard. When the father returned, he did not see the child, but saw the twin. The father located the child in the swimming pool, under the cover. The child was unresponsive and not breathing. He was taken into the home where CPR was performed until EMS responded and transported the child to the hospital where he was pronounced deceased at 8:27 PM.

NCDSS made multiple collateral contacts including medical personnel, first responders and relatives. The medical examiner and hospital doctor believed the child was submerged for approximately 10 minutes prior to being pulled from the water. Upon arrival to the hospital, the child’s body temperature was lower than expected given the amount of time the child was said to be in the water; however, law enforcement did not take a temperature reading of the pool’s water. The hospital doctor stated the child’s body would have initially sank immediately after drowning, and the body’s gases would have later caused the body to float.

NCDSS conducted home visits and met with family members and interviews were appropriate. Although the Safety Assessments were completed timely and accurately, the Risk Assessment Profile did not reflect the child’s death was a result of abuse or maltreatment. Although the investigation revealed some credible evidence the twins were not being properly supervised when the child fell into the pool and was unable to immediately be located, NCDSS unsubstantiated the allegations of Inadequate Guardianship and Lack of Supervision for the twins, and unsubstantiated the allegation of DOA/Fatality against the father.

PIP Requirement

NCDSS will submit a PIP to the Buffalo Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the NCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, NCDSS 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

Explain:
The future risk of the children was not accurately reflected in the Risk Assessment Profile and the investigation determination was not supported by information within the case record.

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:
The Risk Assessment Profile was completed inaccurately, resulting in a low risk rating. The outcome of the Risk Assessment Profile should have been a very-high risk rating.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The Risk Assessment Profile should have resulted in a very-high risk rating; however, the Risk Assessment Profile was completed inaccurately as it did not reflect the child died as a result of abuse or maltreatment.
Legal Reference:	18 NYCRR 432.2(d)

Action:	NCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.
Issue:	Failure to provide safe sleep education/information
Summary:	Although they were in the home and documented sleep provisions for the siblings, NCDSS noted the mother was pregnant and did not document a conversation surrounding safe sleep education/information at any point during the investigation.
Legal Reference:	13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1
Action:	NCDSS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.
Issue:	Appropriateness of allegation determination
Summary:	Based on the age of the child and twin, the level of supervision did not meet the minimum degree of care, and this led to the child's death.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	NCDSS will refer to the CPS Program Manual and/or consult with the Buffalo Regional Office when determining the appropriateness of allegations and will take into consideration all information obtained during the investigation when applying the circumstances to the definition(s).

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/27/2020 **Time of Death:** 08:27 PM

Time of fatal incident, if different than time of death: 07:30 PM

County where fatality incident occurred: Niagara
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
- ☐ 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:

- ☐ Drug Impaired
- ☒ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☒ Distracted
- ☐ Impaired by illness

☐ Impaired by disability ☐ 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	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	36 Year(s)
Deceased Child's Household	Mother	No Role	Female	35 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

LDSS Response

On 5/28/2020, NCDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, NCDSS completed a CPS history check, coordinated the investigation with law enforcement and made a home visit. The siblings were assessed to be safe in the care of the parents. The medical examiner and district attorney's offices were made aware of the death.

Law enforcement provided information that on 5/27/2020, the mother was inside of the home while the father was outside with the children. The father went into the garage to get the older children while leaving the subject child and his twin in the backyard. The father looked for the subject child and located him in the family's inground swimming pool, under the solar cover. The father pulled the child from the water and began CPR. The father reported to law enforcement that the subject child and his twin were left unattended for approximately 1-2 minutes. Law enforcement did not have concerns for the safety of the surviving children.

On 5/29/2020, NCDSS interviewed the parents together at the family's home. The record noted the backyard was fenced in; however, there was not a fence surrounding the pool itself. The mother said the parents were researching pool fences and had moved into the home a few months prior. According to the mother, the children would usually play in the driveway and front yard. On 5/27/2020, the mother was outside with the children while the father napped after work. Around 6:00 PM, the father came outside where the family spent time together prior to the mother going inside approximately 15 minutes later as she was too hot. She reported being inside for approximately 10 minutes before the father ran inside holding the child. The child was placed on the table, CPR was performed and 911 was called. First responders arrived, took over resuscitation efforts and transported the father and child to the hospital via ambulance.

The father said the two oldest children ran into the garage and he followed them as there were tools accessible to the children. The father went into the garage to stop the children and came out of the garage 15-20 seconds later. He saw the twin next to the pool but did not see the subject child. He looked around for the subject child and stated that the yard does not have places for the child to hide. The twin pointed at the pool. The father crouched down, lifted the cover and found the child floating underneath. He took the child out of the pool and ran into the home calling for the mother to help. To prevent future incidents, the father said all doors and gates would be locked and the children would not be able to play in the backyard and would not have access to the pool.

During the home visit, the siblings were observed and interacted with the caseworker, but did not provide any information regarding the fatal incident.

NCDSS gathered collateral information from hospital staff and the medical examiner. The hospital doctor stated it was believed by medical personnel that the child was submerged in the pool for approximately 10 minutes. Additionally, the medical examiner believed the child was in the water between four and eleven minutes.

Several collateral contacts were made including calls to the maternal grandparents and paternal grandfather, who had no concerns for the care of the children. The paternal grandfather assisted the family in obtaining pool alarms and a fence which were installed prior to case closure. The family declined services offered by the Department as they had a strong support group and church community. The case was unsubstantiated and closed on 6/15/2020.

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?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
054225 - Deceased Child, Male, 1 Yrs	055104 - Father, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
054225 - Deceased Child, Male, 1 Yrs	055104 - Father, Male, 36 Year(s)	Lack of Supervision	Unsubstantiated
054225 - Deceased Child, Male, 1 Yrs	055104 - Father, Male, 36 Year(s)	DOA / Fatality	Unsubstantiated
055107 - Sibling, Male, 1 Year(s)	055104 - Father, Male, 36 Year(s)	Inadequate Guardianship	Unsubstantiated
055107 - Sibling, Male, 1 Year(s)	055104 - Father, Male, 36 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?	☒	☐	☐	☐
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: The Risk Assessment Profile was completed inaccurately as the child's death was not considered as maltreatment.				

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:
The family was referred to the Child Advocacy Center in response to the death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents were offered services in response to the fatality; however, they declined services as they had a strong support group through their church.

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

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

There is no CPS history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

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