Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-23-013

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

Issue Date: Aug 15, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 7 year(s)
Jurisdiction: Tioga
Gender: Female
Date of Death: 03/07/2023
Initial Date OCFS Notified: 03/07/2023

Presenting Information

An SCR report received on 03/07/23 alleged that on 03/05/23, at approximately 9:00 AM, the mother left the 7-year-old child alone and unsupervised in the bathtub for about 5 minutes. The mother checked on the child and found her under the water and blue in color. The mother removed the child from the bathtub and performed CPR. EMS arrived at the home, intubated the child, and transported her to the hospital. On 03/07/23, the child was pronounced deceased at 2:44 PM. The mother left the child unsupervised, resulting in her death by drowning. The SCR registered a report on 03/07/23 regarding the fatal incident.

Executive Summary

This fatality report concerns the death of the 7-year-old child that occurred on 03/07/23. A report made to the SCR on the same day alleged the child was left unsupervised in a bathtub, which resulted in her death. The death occurred during an investigation into the fatal incident that began on 03/05/23. At the time of her death, the child resided with her parents and siblings, aged 9 and 12 years. The siblings were assessed to be safe with the parents.

Tioga County Department of Social Services (TCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report regarding the fatal incident. Law enforcement believed the death was accidental; the outcome of the criminal investigation remained unknown. An autopsy was performed, and the medical examiner determined the cause of death to be drowning with a contributory cause of Corona (COVID-19) viral infection and febrile seizures. The manner of death was an accident.

The parents were interviewed by TCDSS and law enforcement, providing consistent recollections of the fatal incident. The parents reported the child acted normally on 03/05/23 and was in the bathtub. The mother left the child unsupervised for approximately 5 minutes while she was in a nearby room attending to a sibling. The mother noticed the child was quiet, checked on her, and found her unresponsive in the bathtub. The 12-year-old sibling called 911. First responders arrived at the home, performed CPR and transported the child to the hospital, where she was pronounced braindead and subsequently succumbed to her injuries.

TCDSS gathered collateral information from hospital staff, medical personnel and first responders. There were no concerns for the surviving siblings.

The record did not reflect a 7-day Safety Assessment was completed in the fatality investigation. Although completed, the 30-day Safety Assessment was completed untimely on 07/14/23. At the time this report was written, the record did not reflect the family was offered services in the response to the death, including burial assistance and bereavement counseling. It remained unknown if the family had service needs, or if they were engaged in therapy. The record did not reflect up to date casework activity and the allegations had not yet been determined at the time of this writing.

PIP Requirement

TCDSS will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the TCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, TCDSS 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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was written.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
Casework activity was not commensurate with case circumstances as the 7-day and 30-day Safety Assessment requirements were not met. At the time this report was written, the record did not reflect casework activity for 8 weeks. It remained unknown if service referrals were offered to the family.

Was the decision to close the case appropriate? N/A

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 investigation remained open at the time this report was written.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Seven Day Assessment
Summary:	Although a 7-day Safety Assessment was completed timely in the investigation regarding the fatal incident, the record did not reflect a 7-day Safety Assessment was completed in the investigation regarding the death.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	TCDSS will document and approve all Safety Assessments within the required timeframes.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The record reflected the 30-day Safety Assessment was completed untimely on 07/16/23; however, it

	remained unknown how the safety of the siblings was assessed as the record did not reflect the siblings were assessed after 03/09/23.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	TCDSS will document and approve all Safety Assessments within the required timeframes.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/07/2023 **Time of Death:** 02:44 PM

Date of fatal incident, if different than date of death: 03/05/2023
Time of fatal incident, if different than time of death: 09:00 AM

County where fatality incident occurred: Tioga
Was 911 or local emergency number called? Yes
Time of Call: 08:44 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Bathing

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	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)

LDSS Response

On 03/05/23, TCDSS received an SCR report alleging the 7-year-old child was left unsupervised in a bathtub and was subsequently hospitalized. Immediately upon receipt of the report, TCDSS gathered information from the hospital social worker and law enforcement. A subsequent report was received on 03/07/23, alleging the child's death.

TCDSS gathered information from the hospital social worker who reported the child was left unsupervised in a bathtub while the mother cut a sibling's hair. The mother noticed the child was quiet, so she returned to the bathroom and saw the child underwater and not moving. The mother took the child out of the water and began CPR. A call was made to 911 and first responders rendered aid to the child. They were able to regain a pulse and transported the child to the hospital. Hospital staff reported the child would undergo brain death testing, stating she had a poor prognosis and was unlikely to survive.

Law enforcement provided TCDSS with information they gathered from the parents. The parents reported the child was sitting in the bathtub when the mother went to an adjacent room to cut the sibling's hair. The mother could not see the child from the other room. The mother stopped hearing the child and went to check on her, finding the child unresponsive. The 12-year-old sibling called 911.

The mother stated she took the child out of the bathtub and put her on the floor. The child was blue and lifeless. The mother administered CPR. The father instructed the sibling to call 911. EMS responded and transported the child to the hospital.

The father reported 03/05/23 was a normal day and the child acted fine. The mother drew the child a bath, keeping the door open. This was common practice for the family. The father was in the bathroom talking to the child and then went to lay on the couch. The father heard the mother screaming and he went into the bathroom. The parents administered CPR. The father's recollection of the fatal incident was consistent with that of the mother.

The hospital notified TCDSS of the death and a report was made to the SCR. Within the first 24 hours of the investigation, TCDSS contacted the source of the report, assessed the safety of the siblings, documented a CPS history check, contacted law enforcement, and notified the district attorney and medical examiner's offices of the death.

On 03/09/23, the siblings were interviewed at the Child Advocacy Center. The 9-year-old sibling reported the child regularly took baths alone and that the parents would check on her. The 12-year-old sibling reported he called 911. The siblings did not provide additional information regarding the fatal incident.

At the time this report was written, the investigations into the fatal incident and the death remained open.

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?No
Comments: Tioga County does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

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

064371 - Deceased Child, Female, 7 Yrs	064374 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Pending
064371 - Deceased Child, Female, 7 Yrs	064374 - Mother, Female, 37 Year(s)	Lack of Supervision	Pending
064371 - Deceased Child, Female, 7 Yrs	064375 - Father, Male, 38 Year(s)	Inadequate Guardianship	Pending
064371 - Deceased Child, Female, 7 Yrs	064375 - Father, Male, 38 Year(s)	Lack of Supervision	Pending
064371 - Deceased Child, Female, 7 Yrs	064374 - Mother, Female, 37 Year(s)	DOA / Fatality	Pending

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?	☐	☐	☒	☐
Explain: Although a 30-day Safety Assessment was completed, it was completed untimely on 07/14/23. At that time, there were no progress notes reflecting casework activity; therefore, it remained unknown how the safety of the siblings was assessed at that time.				

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 record did not reflect possible services needs for the family were explored.				

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐
Explain as necessary: The siblings did not need to be removed as a result of the 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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The record did not reflect the family was provided with service referrals in response to the death.

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? No
Explain:
The record did not reflect the siblings were offered services in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The record did no reflect the parents were provided with referrals for services in response to the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? Yes

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 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.

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