Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-23-029

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

Issue Date: Nov 09, 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: 4 year(s)
Jurisdiction: Jefferson
Gender: Male
Date of Death: 06/11/2023
Initial Date OCFS Notified: 06/11/2023

Presenting Information

On 6/11/2023, Jefferson County Department of Social Services (JCDSS) received an SCR report alleging the death of the 4-year-old subject child which occurred that day. The subject child had been unsupervised while in the care of the mother and father and went missing for an unknown period of time. The subject child was later found unresponsive in a pond. Emergency medical services responded and performed cardiopulmonary resuscitation (CPR) while transporting the subject child to the hospital. Life saving measures were continued upon the subject child's arrival at the hospital; however, the subject child was pronounced deceased at 10:20 PM. There were an unknown number of surviving siblings listed on the SCR report with unknown roles.

Executive Summary

This report concerns the death of the 4-year-old subject child which occurred on 6/11/2023. At the time of his death, the subject child resided with the mother, father, and surviving siblings ages 11, 10, 8, 6, 5, 3, and 2 years and 10 months. JCDSS assessed the surviving siblings to be safe in the care of the parents immediately upon receipt of the SCR report.

On 6/11/2023, the subject child and multiple siblings were outside of the home unsupervised from about 5:30 PM to about 7:30 PM. The children were playing, building forts on the family's property, and completing barn chores. Around 7:30 PM, the father went outside to tell the children to return to the home for the evening and the subject child was not with his siblings. The siblings told the father they believed the subject child was inside the house with the parents. The father searched the home and the property and found the subject child face-down in a pond on the family's property. The father did not enter the pond to retrieve the subject child, as he was unable to swim. The father traveled to the nearest neighbor's home, about ¼ mile away, and contacted emergency services.

Law enforcement and emergency medical services arrived at the home and the father directed them to the pond. Law enforcement personnel retrieved the subject child from the pond, and he was not breathing, unresponsive, with no pulse, and cold, with an internal temperature of about 71 degrees Fahrenheit. Initially, the father asked that emergency medical providers not provide CPR to the subject child, as he believed the subject child was already deceased. Emergency medical technicians spoke with a supervisor and persuaded the father to allow them to perform CPR, which began on site and continued while the subject child was transported to the hospital via ambulance. Emergency life-saving measures continued at the hospital; however, the subject child was pronounced deceased at 10:20 PM.

First responders and hospital staff reported no concerns for foul-play or trauma related to the death of the subject child and stated there was no sign the death was related to anything other than accidental drowning. First responders reported the father's initial hesitancy to allow CPR was unlikely to have contributed to the death in any way.

Per the family's religion, an autopsy was not performed by the medical examiner. The death certificate noted the manner of death was "Accidental" and immediate cause of death was "Asphyxiation as a consequence of cold-water drowning." The law enforcement investigation was closed on 7/14/2023 with no charges or arrests and law enforcement records noted the circumstances surrounding the death were consistent with an accidental drowning.

The allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision were substantiated against the mother and father regarding the subject child. The Investigation Conclusion Narrative noted the mother and father allowed the subject child to be outside with no adult supervision for a period of 2 hours, during which time he fell into the pond and

drowned.

JCDSS offered fatality-related services to the parents and surviving siblings; however, the parents declined all services, stating they would seek support from their community.

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

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:
JCDSS conducted an investigation that met regulatory requirements. Home visits and familial interviews were conducted immediately upon receipt of the report. Records were gathered from pertinent collaterals. The determination of the allegations was made in congruence with information gathered.

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: 06/11/2023 **Time of Death:** 10:20 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: 08:37 PM
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
- ☒ Playing
- ☐ Other
- ☐ Working
- ☐ Eating
- ☐ Driving / Vehicle occupant
- ☐ Unknown

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	4 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Month(s)

LDSS Response

Immediately upon receipt of the SCR report, JCDSS visited the hospital, arranged a home visit with the father, and gathered information from law enforcement and medical staff. The DA's office was notified in a timely manner and a history search was conducted showing the family had no prior involvement with CPS.

The father and mother declined to be interviewed separately. The parents reported the children went outside around 5:30 PM on 6/11/2023 to play on the family's property, complete barn chores, and build forts. The father reported he went outside around 7:30 PM to look at the children's forts and to tell them it was time to come in. The father stated the subject child was not with his siblings, and the siblings reported to him they believed the subject child was in the house with the father. The father stated he searched the house and checked the barn and began to search the property. The father stated he observed the subject child face-down on the bottom of the pond but did not enter the water to get the subject child as he

himself could not swim. The father believed the subject child was already deceased at that time and left to go to a neighbor's home to contact emergency services. The mother and father stated the children are aware they are not to go near or into the pond without an adult.

The parents were interviewed regarding alcohol, substances, health, mental health, and other general topics and denied any issues within the family. The parents reported they disciplined their children according to the bible; however, would not elaborate as to what that meant. The parents reported the children have not been to a pediatrician and do not attend public school due to the family's religious beliefs. The parents declined to sign any releases of information for JCDSS. The parents reported they followed safe sleep "for the most part" and declined to discuss their safe sleep practices with JCDSS. The parents reported the children under 2 years of age sleep in a wooden crib. JCDSS provided the parents with safe sleep literature.

JCDSS discussed supervision with the mother and father at length during multiple home visits. The parents agreed that the children will be supervised and will not be allowed near the pond at any time. The father agreed to install a fence or other deterrent around the pond.

JCDSS attempted to interview the 10 and 11-year-old surviving siblings as they were the only children in the home that spoke English. The surviving siblings did not answer questions when interviewed and did not disclose any details regarding the death of the subject child. JCDSS observed all surviving siblings to be clean, appropriately dressed, and free of suspicious injury. The children appeared well and appeared comfortable in the care of their parents.

The mother was pregnant and gave birth during the investigation. The parents declined to allow JCDSS to see the new baby. JCDSS was able to speak with the midwife who delivered the new baby and checked in on the baby the next day. The midwife stated the baby was born healthy and she had no concerns for the new baby or the other surviving siblings in the care of the parents.

JCDSS spoke with the neighbor whose phone the father used to contact 911. The neighbor stated he had no concerns for the subject child or surviving siblings in the care of the parents.

JCDSS conferenced with their legal department regarding the parents' lack of cooperation with JCDSS, lax supervision of the children, the danger of the pond remaining on the property, and the parents' refusal to allow JCDSS to observe the newborn baby. It was decided a petition would not be filed in family court.

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

SCR Fatality Report Summary

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

065188 - Deceased Child, Male, 4 Yrs	065189 - Mother, Female, 32 Year(s)	DOA / Fatality	Substantiated
065188 - Deceased Child, Male, 4 Yrs	065189 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
065188 - Deceased Child, Male, 4 Yrs	065189 - Mother, Female, 32 Year(s)	Lack of Supervision	Substantiated
065188 - Deceased Child, Male, 4 Yrs	065190 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
065188 - Deceased Child, Male, 4 Yrs	065190 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
065188 - Deceased Child, Male, 4 Yrs	065190 - Father, Male, 34 Year(s)	Lack of Supervision	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	☒	☐	☐	☐

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?	☐	☒	☐	☐

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? No
Explain:
Fatality related services were offered but were declined by the parents.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
Fatality related services were offered but were declined by the parents.

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? 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 was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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