NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: BU-15-024 **Prepared by: Buffalo Regional Office**

Issue Date: 4/27/2016

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
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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Wyoming
Gender: Male
Date of Death: 07/05/2015
Initial Date OCFS Notified: 07/06/2015

Presenting Information

On 07/06/15, Wyoming County Department of Social Services (WCDSS) received an initial report from the State Central Register (SCR) regarding the subject child (SC) with allegations of DOA/Fatality (DOA), Internal Injuries (II), Inadequate Guardianship (IG) and Lack of Supervision (LOS). The report alleged that on 07/02/15, the SC was riding a gas powered All Terrain Vehicle (ATV) on his grandparent's property while the grandmother (GM) was mowing the lawn and the grandfather (GF) was stacking wood. After about 10 minutes, the grandparent's realized that they had not seen the SC. The SC was found unconscious, face down in a pond on the property. The grandparents were listed as subjects of the report. The mother (MO) and father (FA) were listed with unknown roles.

The Erie County Department of Social Services was assigned with a secondary role as the SC was transported to a hospital in Buffalo, NY for further care and treatment prior to his death.

Executive Summary

This fatality report concerns the death of a 3-year-old male that occurred on 07/05/15. WCDSS received an initial SCR report in regards to the SC 07/06/015 with allegations of Dead on Arrival/Fatality (DOA), Inadequate Guardianship(IG), Internal Injuries (II) and Lack of Supervision (LOS). The PGM and PGF were listed as the subjects of the report. The BM and BF were listed with unknown roles.

On 08/11/15, WCDSS unfounded and closed the report citing that the death was “accidental” and that charges were not filed by law enforcement. The determination to unfound the report was inappropriate as the evidence gathered by WCDSS did support a finding of maltreatment. There was some credible evidence that the PGM failed to provide a minimum degree of care for the SC and that the failure to provide a minimum degree of care caused impairment to the SC.

It would have been appropriate for WCDSS to utilize NYS policy 11-OCFS-LCM-01, “Guidance for CPS Investigations involving Activities Regulated by Other Local or State agencies”. The policy provides guidance to CPS staff regarding the investigation and determination of CPS reports, including fatality reports, which involve activities that are also subject to regulation or oversight by government agencies outside of the child welfare system. It would have been essential to utilize this policy for guidance regarding the determination due to the fact that the SC was operating a gas powered ATV. The New York state Vehicle & Traffic Law regulates the operation of ATV’s by children.

On 07/02/15, The SC nearly drowned after being allowed to operate a gas powered ATV unsupervised near a 7 foot deep pond for an undetermined amount of time, based on the SC’s age he should have been supervised by an adult while riding the ATV at all times. According to medical records, it is likely that the SC was submerged in water for at least 23 minutes due to the significance of the brain injury. The SC was admitted to the hospital on 07/02/15, placed on life support and it was determined that he was in very critical condition. Subsequently, the SC died on 07/06/15.

According to the autopsy report the cause of death was due to complications of a near drowning and the manner of

death was accidental. Although, the ME and LE determined that the death was accidental, it does not mean that the SC was not maltreated. It indicates, that the PGM did not intend to cause the death of the SC. However, intent is not an element of maltreatment. The SC sustained significant internal injuries and subsequently died due to complications of a near drowning. The SC nearly drowned due to the fact that the PGM failed to provide him with proper supervision. There is a casual connection between the death of the SC and the PGM's failure to adequately supervise him.

WCDSS initiated the investigation timely and completed adequate safety/risk assessments. A joint investigation was not conducted with LE due to the fact that WCDSS did not receive notification of the incident until after the death of the SC. Upon receiving the report from the SCR, WCDSS conducted appropriate collateral contacts and obtained records from LE and the attending hospital however, WCDSS did not conduct collateral contacts or obtain relevant records from Emergency Medical Services.

As a result, there are 2 required actions. WCDSS is required to develop corrective action plans that would support appropriate allegation determinations and contacting/gathering information from all appropriate collaterals prior to determining and closing CPS investigations.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** — 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 determination to unfound the report was inappropriate as the evidence gathered by WCDSS did support a finding of maltreatment. There was some credible evidence that the PGM failed to provide a minimum degree of care for the SC and that the failure to provide a minimum degree of care caused impairment to the SC.

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:
As noted above.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The report was UNF despite having some credible evidence that all 3 elements of maltreatment were present. The PGM did not provide adequate supervision to the SC. As a result he nearly drowned, suffered significant internal injuries and died.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	WCDSS is required to develop an internal plan and process which supports appropriate allegation determinations through critical thinking, supervision and utilization of applicable NYS policies (ADM's, LCM's and INF's) regarding the investigation and determination of CPS reports.
Issue:	Contact/Information From Reporting/Collateral Source
Summary:	WCDSS did not conduct a collateral contact with Emergency Medical Services (EMS) first responders during the fatality investigation.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	WCDSS is required to develop an internal plan and process which supports identifying, contacting, and gathering information from all appropriate collateral contacts prior to determining and closing CPS investigations.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/05/2015 **Time of Death:** 02:50 PM

Date of fatal incident, if different than date of death: 07/02/2015
Time of fatal incident, if different than time of death: 02:10 PM

County where fatality incident occurred: WYOMING
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS to 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
Is the caretaker listed in the Household Composition? No

At time of incident supervisor was:

☐ Drug Impaired
☐ Alcohol Impaired
☐ Distracted
☐ Impaired by disability
☒ Absent
☐ Asleep
☐ Impaired by illness
☐ Other:

Total number of deaths at incident event:

Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim		3 Year(s)
Deceased Child's Household	Father	No Role	Male	35 Year(s)
Deceased Child's Household	Mother	No Role	Female	28 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	60 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Male	64 Year(s)

LDSS Response

WCDSS responded to the death of the SC by verifying that there were no surviving siblings and making contact with the source of the report on 07/07/16. The source of the report confirmed the narrative of the SCR report and further stated that the SC had suffered a significant brain injury and if he had survived, would have been non-verbal and non-ambulatory. On the same day WCDSS, conducted a collateral contact with Law Enforcement. According to LE, criminal charges were not filed against any of the caretakers in regards to the incident. LE interviewed the grandparents on 07/02/15 immediately after the incident.

WCDSS conducted face-to-face interviews with the birth parents on 7/7 and with paternal grandparents on 7/7 & 7/29. It was reported that on 07/02/16, the SC was in the care of the paternal grandparents at their home. The BM and BF were at work. This was a typical routine as the grandparent's had provided care for the SC since birth while the parents worked. It was determined that the SC was outside with the PGM at the time of the incident. During this time the PGM was riding a lawn mower. The PGF was inside the home and was not stacking wood as the initial report stated. The SC was riding a 2015 Polaris Outlaw 50 cc four wheeled gas powered ATV around the property.

At some point, he told the GM that he wanted to go inside with the GF. The GM gave the SC permission to do so and reported that she watched him ride towards the house on the ATV for about a ¼ of the way down a path near the pond. As per the LE report, she continued mowing the lawn for about 10 minutes; she then rounded the pond on the east edge and observed the SC in the pond. It should be noted that the GM informed CPS that she made another "sweep" with the lawn mower and then looked for the SC as she did not see him. WCDSS did not clarify this with the GM, it's not clear as to how long it took the GM to make what she referred to as another "sweep" and/or how long it had been since she had actually seen the SC. Another inconsistency that should have been clarified is the reason as to why the GM looked for the SC, if she believed that he was going inside the house. The GM reported that she went to the other side of the pond and saw the flag on the back of the ATV sticking out of the pond. She informed LE that she yelled for the GF and when he came out

they removed the SC from the pond and that she called 911. She informed CPS that she pulled the SC from the pond and then started screaming. The GF responded and started CPR while the GM called 911. It would have been important for WCDSS to clarify all inconsistencies to gain a clearer understanding of the events leading up to the incident and after the SC was discovered in the pond.
LE and EMS responded to the case address and determined that the SC was unconscious and without a pulse. The SC was intubated and transported to the hospital for further care.

Upon arriving to the hospital the SC had a pulse, the SC was placed on a ventilator and it was determined that he suffered an anoxic brain injury. As per medical providers due to the extent of the SC's brain injury it is likely that he was submerged in water for at least 23 minutes. On 07/05/16 the parents made the decision to remove the SC from life support.

According to the LE report, there were not any other factors that contributed to the accident. As the SC was operating the ATV during daylight hours and the road surface was dry. In addition, the SC was wearing a helmet and the ATV had several safety features including the ability to set the throttle. The throttle was set at the lowest level. LE did not file any criminal charges regarding the incident.

It remains unknown as to what caused the SC to ride his ATV into the water, despite the fact that he was allowed to operate the ATV without direct adult supervision.

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)?No
Comments: A joint investigation was not conducted with LE due to the fact that WCDSS was not notified of the incident until after the death of the SC. Upon receiving the report from the SCR, WCDSS conducted appropriate collateral contacts with LE to obtain information regarding the circumstances related to the near-drowning incident.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
027065 - Deceased Child, , 3 Yrs	027072 - Grandparent, Male, 64 Year(s)	Lack of Supervision	Unsubstantiated
027065 - Deceased Child, , 3 Yrs	027073 - Grandparent, Female, 60 Year(s)	DOA / Fatality	Unsubstantiated
027065 - Deceased Child, , 3	027073 - Grandparent, Female, 60	Internal Injuries	Unsubstantiated

Yrs	Year(s)		
027065 - Deceased Child, , 3 Yrs	027073 - Grandparent, Female, 60 Year(s)	Lack of Supervision	Unsubstantiated
027065 - Deceased Child, , 3 Yrs	027072 - Grandparent, Male, 64 Year(s)	Inadequate Guardianship	Unsubstantiated
027065 - Deceased Child, , 3 Yrs	027073 - Grandparent, Female, 60 Year(s)	Inadequate Guardianship	Unsubstantiated
027065 - Deceased Child, , 3 Yrs	027072 - Grandparent, Male, 64 Year(s)	DOA / Fatality	Unsubstantiated
027065 - Deceased Child, , 3 Yrs	027072 - Grandparent, Male, 64 Year(s)	Internal Injuries	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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?	☐	☒	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☐	☒	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

WCDSS did not conduct a collateral contact with EMS first responders.

WCDSS did not conduct a collateral contact with the SC's pediatrician.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	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 within three years prior to the fatality.

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

No CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

No known CPS history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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