Child Fatality Report

Report Identification Number: RO-19-012

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

Issue Date: Sep 11, 2019

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		

Case Information

Report Type: Child Deceased
Age: 8 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 03/23/2019
Initial Date OCFS Notified: 03/23/2019

Presenting Information

An SCR report received on 3/23/19 alleged the mother left the 8-year-old subject child unsupervised for an unknown length of time. As a result, the child was found unresponsive in a swimming pool and was later pronounced deceased. A subsequent report was received on 3/24/19 alleging the aunt and subject child were attending a birthday party at a hotel. The aunt and child visited the hotel's indoor swimming pool. While at the pool, the aunt was approximately 15 feet away from the pool, tending to another child and failed to supervise the subject child. As a result, the subject child went into the deep end. At 8:34 PM, the child went underwater. At 8:46 PM, an unknown adult entered the pool, noticed the child at the bottom and pulled her out. She had been underwater for 11 minutes. First responders attempted CPR. The child was transported to a medical facility where she was pronounced deceased.

Executive Summary

This fatality report concerns the death of the 8-year-old female child (SC) that occurred on 3/23/19. Two SCR reports were made regarding the death on 3/23/19 and 3/24/19. There were three surviving siblings (aged 6, 10 and 12 years) who resided with the child and an adult sibling who were assessed to be safe in the care of their mother. Three surviving cousins (aged 1, 9, and 12 years) resided with their mother, the maternal aunt, were assessed to be safe.

Monroe County Department of Human Services (MCDHS) coordinated investigative efforts with law enforcement upon receipt of the fatality report. An autopsy was performed; however, only a partial autopsy was performed due to the family's religious beliefs. The Medical Examiner determined the cause of death "drowning" and the manner of death as accident.

The mother (SM) reported the adult sibling and the maternal aunt (MA) took the female children (aged 1, 8, 9, and 10 years) to a hotel for a birthday party. The mother stayed home with the male children. The maternal aunt and adult sibling reported the children were at the hotel's swimming pool, while the aunt supervised the children in the pool area. The aunt was unaware the child went into the deep end of the swimming pool and went underwater. A bystander saw the child at the bottom of the pool, pulled her out of the water and began CPR.

A call was made to 911 and first responders arrived on scene and took over lifesaving efforts. The child was transported to the hospital, where she was pronounced deceased at 9:56 PM.

MCDHS gathered information about the child's death from the family, the Medical Examiner, hospital staff and first responders, including their records.

Multiple home visits were made to both the maternal aunt and the child's homes during the investigation. The children were observed to be safe in the care of their mothers.

The family was offered an abundance of services including mental health and bereavement counseling, trauma-based services and burial assistance.

MCDHS completed required reports and Safety Assessments timely and accurately and completed a thorough investigation. MCDHS appropriately substantiated the allegations of Inadequate Guardianship, Lack of Supervision and DOA/Fatality against the aunt as credible evidence was revealed to support the allegations. The aunt was responsible for

the care of the child when she drowned. MCDHS appropriately unsubstantiated the same allegations with regard to the mother as she was not present for the fatal incident.

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:
The casework activity was commensurate with the case circumstances.

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:
The case was appropriately determined and closed.

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: 03/23/2019 **Time of Death:** 09:56 PM

Time of fatal incident, if different than time of death: 08:34 PM

County where fatality incident occurred: Monroe
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? Yes
How long before incident was the child last seen by caretaker? 15 Minutes
At time of incident supervisor was: Not impaired.

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	Adult Sibling	No Role	Female	20 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	8 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	48 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Other Household 1	Aunt/Uncle	Alleged Perpetrator	Female	32 Year(s)
Other Household 1	Other Child - Cousin	No Role	Male	12 Year(s)
Other Household 1	Other Child - Cousin	No Role	Female	9 Year(s)
Other Household 1	Other Child - Cousin	No Role	Female	1 Year(s)
Other Household 2	Other Adult - BF of Cousin	No Role	Male	31 Year(s)
Other Household 3	Other Adult - BF of Cousins	No Role	Male	35 Year(s)
Other Household 4	Father	No Role	Male	55 Year(s)

LDSS Response

MCDHS received two fatality reports from the SCR and initiated their investigation alongside LE within 24 hours. MCDHS contacted the sources of the SCR reports, completed a CPS history check and notified the ME of the death, and assessed the safety of the surviving children.

On 3/24/19, MCDHS conducted home visits to the SM and MA's homes. The BF resided in New York City, but was at the

home when the interviews took place. He did not have information regarding the death. The BF expressed concern the SC was not properly supervised by the MA.

The SM said the adult SS and MA took the female CHN to a hotel, while she stayed home to care for the male CHN. She did not have any information regarding the death.

The adult SS took the CHN to the pool while the MA stayed in the room. After some time, the 1yo cousin became cold and the adult sibling brought her to the room and the MA went to supervise the other CHN. The MA went to the pool and told the CHN to get out of the water. She saw the 10yo SS jump into the pool and thought the SC followed, but was unsure as she did not see, and was trying to get the CHN out of the pool and tend to them. She saw a man pulling the SC from the pool and he began CPR. First responders arrived and transported the SC to the hospital. The MA was not aware of the pool's deep end, or how deep the water was.

The 9yo cousin said she was at the pool with the MA when the 10yo SS and the SC jumped into the deep end. The cousin saw the SC pulled from the pool, and said the MA did not know the SC had jumped back into the pool. The 10yo SS said a lot of people were in the pool. She also said the 1yo cousin was cold and the adult SS brought her to the room, and the MA came down to watch the CHN.

The 12yo cousin, 12yo SS and 6yo SS were not present for the fatal incident and had no information regarding the death. Their safety was assessed throughout the investigation and were interviewed regarding potential concerns of domestic violence which were revealed during the investigation.

The fathers of the cousins were made aware of the report; however, had no information regarding the death. They did not have concerns for the care the MA provided to her CHN.

LE provided records to MCDHS which included statements from bystanders and first responders. Additionally, a surveillance video was provided. The video showed the MA supervising the CHN with the 1yo cousin on her lap. At 8:33 PM, a person was seen in the deep end of the pool, at 8:46 PM, a man looked into the water, jumped in, pulled out the SC and began CPR. Video showed the SC swimming well in the deep end for some time before struggling and going underwater. The pool water appeared to be murky and was filled with people. LE stated the clarity of the water and population contributed to the drowning. The record noted there was not a lifeguard on duty at the time; however, it was unknown if there was one required to be there. The criminal investigation was closed without any charges, stating the drowning was accidental.

Information was gathered from the man who attempted to rescue the SC from the pool. He dipped his foot in the water to test the temperature, and noticed the SC face down in the deep end. She did not appear to be holding her breath or playing, so he jumped in and raised her to the water's surface. He said she was not breathing when he pulled her out, and he told someone to call 911. The man and a bystander performed CPR until EMS arrived and took over.

MCDHS offered trauma-based services to the family and burial assistance. The MA declined services for herself and CHN; it remained unknown if the family accepted any of the services at the time of case closure. The family did not utilize burial assistance available through MCDHS as the community collected funds to cover the SC's final expenses.

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? No
Comments: The death was referred to the Child Fatality Review Team during the investigation.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050944 - Deceased Child, Female, 8 Yrs	050945 - Mother, Female, 48 Year(s)	DOA / Fatality	Unsubstantiated
050944 - Deceased Child, Female, 8 Yrs	050951 - Aunt/Uncle, Female, 32 Year(s)	Lack of Supervision	Substantiated
050944 - Deceased Child, Female, 8 Yrs	050945 - Mother, Female, 48 Year(s)	Lack of Supervision	Unsubstantiated
050944 - Deceased Child, Female, 8 Yrs	050951 - Aunt/Uncle, Female, 32 Year(s)	DOA / Fatality	Substantiated
050944 - Deceased Child, Female, 8 Yrs	050951 - Aunt/Uncle, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
050944 - Deceased Child, Female, 8 Yrs	050945 - Mother, Female, 48 Year(s)	Inadequate Guardianship	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?	☒	☐	☐	☐

Additional information:
Although the fathers of the cousins were contacted, one father was not seen face-to-face as he resided in Africa.

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 parents were interested in services for themselves and the siblings; however, the aunt declined services for herself and her children.				

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?	☐	☒	☐	☐
Explain as necessary: There were no safety factors identified that would require the children to be removed.				

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:
It was unknown if the family participated in grief counseling due to the fatality. Although the family was offered burial assistance, the funeral costs were provided by funds donated by the community.

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 children were offered trauma based services from their schools and the community.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was provided with information for trauma based services; however, the aunt declined any services.

History Prior to the Fatality

Child Information

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

1/20/06- 3/9/06 OA UnSub for IG, L/B/W for SS and OA Sub for IG, L/B/W regarding SS.

9/10/09- 10/14/09 MA UnSub for IG and LS regarding OC.

3/7/10- 4/20/10 MA UnSub for IG regarding cousin.

9/11/15- 5/13/16 MA and MU UnSub for IG regarding cousins.

7/12/12- 7/31/12 MA UnSub for IG and L/B/W regarding cousins. MU Sub for IG and L/B/W regarding cousins.

10/4/12- 12/31/12 BM Sub for XCP and IG regarding SS and UnSub for S/D/S.

Known CPS History Outside of NYS

The is no known CPS history outside of New York State.

Preventive Services History

An FSS was opened on 2/14/06 after being referred by a CPS worker. The case was referred as the family resided in a refugee camp for 4 years where the SS witnessed his father's murder. The SS had anger issues and made suicidal and homicidal threats. MCDHS provided referrals to Community Based Services and completed appropriate casework activity. The FSS was closed on 3/27/06 after the family achieved their set goals.

An FSS was opened on 4/20/06 after being referred by Hillside Family of Agencies. The family struggled with the father's murder and the SS' behaviors. The mother used XCP to manage the SS's behaviors. The FSS was closed on 1/8/06 as the family achieved their goals and attended anger management and parenting classes.

An FSS was opened on 11/18/09 after being referred by CPS. The 2yo cousin was found scantily clad roaming the hallways of an apartment building without supervision. The MA was pregnant and had minimal familial supports to help manage her toddler. The FSS was closed on 6/18/12 after the family completed their goals.

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