Child Fatality Report

Report Identification Number: AL-22-014

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

Issue Date: Sep 23, 2022

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	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 year(s)
Jurisdiction: Albany
Gender: Male
Date of Death: 04/17/2022
Initial Date OCFS Notified: 04/20/2022

Presenting Information

An SCR report was received on 4/20/22 and alleged that on 4/17/22, the 3-year-old subject child was found unresponsive in a swimming pool. The child was was pronounced deceased as a result of drowning. At the time of the incident, the family was having dinner with relatives and the child went outside unsupervised and accessed an unsecured swimming pool.

Executive Summary

This fatality report concerns the death of a 3-year-old male child that occurred on 4/17/22. The investigation began on 4/20/22, after an SCR report was received with concerns that while unsupervised, the subject child drowned in the paternal aunt's pool. A report was made to the SCR with allegations of Inadequate Guardianship, Lack of Supervision and DOA/Fatality against the mother and father. There were two surviving siblings, ages 9-years-old and 8-months-old, who were assessed to be safe in the care of the parents.

On 4/20/22, Albany County Department of Youth, Children and Families (ACDCYF) learned of the drowning of the subject child and immediately began gathering information related to the incident. It was determined on the day of the death, the father had brought the subject child and 9-year-old sibling to the aunt's home for Easter dinner. There were several adults and children present. The adults periodically checked on the children while they prepared dinner. The father went to check on the subject child and he was not in the room with the other children. The father searched both inside and outside the home, and then inquired with the neighbors if they had seen the subject child. The father and paternal aunt checked the nearby firehouse to see if anyone had located the subject child and brought him there. The subject child was not there and the father called 911. First responders and several community members assisted in searching for the subject child. The subject child was discovered in the pool. First responders began cardiopulmonary resuscitation and transported the subject child to the hospital where he was pronounced deceased.

An autopsy was completed and the cause of death was asphyxia due to drowning. The manner of death was accidental. Law enforcement investigated the fatality and determined there was no criminality regarding the subject child's death. Law enforcement believed the death to be accidental, reported the parents responded appropriately, and first responders that interacted with the adults did not believe they were impaired upon their response to the home.

ACDCYF discussed service needs for the parents, paternal aunt and the 9-year-old sibling. The mother reported the sibling's school had provided information on grief counseling services for the family. The father further stated the 9-year-old was struggling while coping with the death and additional grief counseling services were discussed. In addition, ACDCYF provided the family with written material on resources for grief counseling. ACDCYF unsubstantiated the allegations of Lack of Supervision, Inadequate Guardianship and DOA/Fatality. Although ACDCYF gathered evidence to support their determination, it was not clear from the investigation conclusion narrative how ACDCYF supported their determination, as they provided a summary of information learned during the investigation and did not make the connection between the evidence gathered and their determination. The investigation was unfounded and closed on 6/29/22.

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:
ACDCYF gathered sufficient information to determine the allegations.

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:
Although all other casework activity was commensurate with case circumstances, the Risk Assessment Profile did not accurately reflect the mother's mental health diagnoses.

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 did not accurately reflect the mother's mental health diagnoses.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACDCYF will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/17/2022 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Rensselaer
Was 911 or local emergency number called? Yes
Time of Call: 07:08 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

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

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 was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Asleep
- ☐ Absent
- ☒ Other: **N/A**

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	3 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Month(s)

LDSS Response

Upon receipt of the SCR report on 4/20/22, ACDCYF initiated their investigation and coordinated efforts with law enforcement, notified the district attorney, contacted the medical examiner, interviewed the parents and collaterals, completed a home visit and offered services regarding the fatality.

ACDCYF completed interviews with numerous first responders and learned that on 4/17/22, at 7:08PM, 911 was contacted regarding the child, who was reported to have been missing from the aunt's home since approximately 6:30PM. Upon law enforcement's arrival, the family was unaware of where the child would have gone, as it was his first time at the aunt's home. The child was described as very active and had recently become interested in doorknobs. The aunt's home had two

separate entrances. The front door was deadbolted and the back door had a child-proof door knob. Law enforcement believed the child exited through the back door after one of the adults was smoking a cigarette outside and left the door ajar. First responders searched the home and surrounding area. The pool was checked multiple times with flashlights; however, it was covered in leaves and algae and it was difficult to see. The child was eventually located by a community member who saw the child's hair sticking out of the water.

ACDCYF interviewed the father who reported that on 4/17/22 he brought the child and 9yo sibling to the paternal aunt's home to celebrate Easter. The mother and 8-month-old sibling were supposed to go as well; however, the mother stayed home with the younger sibling because he was fussing. The father, child and 9yo sibling were picked up by a relative between 4:00PM and 5:00PM to go to the aunt's home. Upon arrival, the children played together. The father checked on the child periodically while he helped prepare dinner. Approximately 10 to 15 minutes passed and the father went to check on the child. The child was not with the other children and they did not know where he went. The father checked the rooms inside the house, then went outside and checked the yard, pool and neighbor's homes. The father informed the other relatives and they assisted in looking for the child. The paternal aunt drove around the neighborhood and they could not locate him. The father called 911 for assistance and then notified the mother. The mother went to the paternal aunt's home after the father notified her of the child missing. ACDCYF completed a brief interview with the 9yo sibling, who provided minimal details regarding the incident before she was unwilling to further participate in the interview.

Law enforcement reported there were several violations regarding the above ground pool and Code Enforcement was contacted. There was no cover on the pool, no fence around the pool, and no alarms. There was a makeshift gate blocking the stairs leading up to the pool. Through a fingerprint analysis it was discovered, there were smudged fingerprints on the skimmer box that was near the ground and a short distance from the filter which could have been how the child climbed and hoisted himself into the pool. ACDCYF noted during a home visit that the pool was taken down following the child's death. The aunt had moved into the home in March and was renting. The landlord immediately hired an attorney due to the code violations.

ACDCYF completed visits to the parents' and aunt's home and assessed the cousins' and surviving siblings' safety. The surviving siblings were up to date on medical appointments and there were no concerns reported for their well-being. Safe sleep environments were observed for the children and safe sleep guidance was provided.

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
Comments: The fatality was reviewed by Albany County's CFRT on 4/25/22.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060976 - Deceased Child, Male, 3 Yrs	060977 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated

060976 - Deceased Child, Male, 3 Yrs	060977 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
060976 - Deceased Child, Male, 3 Yrs	060977 - Mother, Female, 35 Year(s)	Lack of Supervision	Unsubstantiated
060976 - Deceased Child, Male, 3 Yrs	060978 - Father, Male, 37 Year(s)	DOA / Fatality	Unsubstantiated
060976 - Deceased Child, Male, 3 Yrs	060978 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
060976 - Deceased Child, Male, 3 Yrs	060978 - Father, Male, 37 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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:

The record did not reflect that all of the CHN and adults at the PA's home when the SC went missing were interviewed. Although the pediatrician was contacted about the SSs, there was no information documented regarding the SC.

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 did not accurately reflect the mother's mental health diagnoses.				

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The family was offered information on counseling services. The record did not reflect that funeral assistance was offered.

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:
ACDCYF and the 9yo sibling's school offered grief counseling on behalf of the sibling.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACDCYF offered the parents grief counseling services.

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

In 2013, the mother had a CPS FAR case in Rensselaer County after the 9yo sibling was born with a positive toxicology for marijuana. The mother admitted to the use of marijuana. Rensselaer County Department of Social Services referred the family to Healthy Families and they engaged in the services offered. There were no safety concerns and the FAR case was closed.

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