NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: SY-15-023 **Prepared by: Syracuse Regional Office**

Issue Date: 2/17/2016

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: 9 year(s)
Jurisdiction: Jefferson
Gender: Male
Date of Death: 05/19/2015
Initial Date OCFS Notified: 05/19/2015

Presenting Information

On 5/19/15 at approximately 3:15pm, nine year-old SC was outside playing with his siblings. The children were not adequately supervised and were playing with a heavy, metal dump cart that was on wheels. SC and his siblings were rolling the cart down a dirt ramp that leads up into the barn. Grandmother saw the children, told them to stop before someone got hurt, and went into the home. The children continued to play. As SC was rolling down the ramp, the cart went off the left side of the ramp. The cart struck rocks and overturned, ejecting SC and rolling over onto his head. SC died instantly as a result. The roles of mother, father and siblings were unknown.
Mother was present in the home but was not aware of the children playing with the cart. Father was believed to not have been home at the time.

Executive Summary

This review concerns the fatality of a nine-year old male child who died from blunt force trauma as a result of an accident involving farm equipment. On 5/19/15 at approximately 3:15pm, the SC and four siblings (ages 7, 8, 8, and 10) were playing unsupervised in a large metal cart on the farm property where they resided with eight other siblings, their mother and father, as well as the paternal grandparents. The children were rolling the cart down a dirt ramp while they rode inside of the bucket area. As this was occurring, the cart went off the left side of the ramp, struck rocks and overturned, and ejected the SC before landing on his head, killing the SC instantly. Sometime prior to this incident, the children's PGM had seen the children playing in the cart and had instructed them to be stop but then continued to leave the children unsupervised. The SM was inside the home at the time and was also not properly supervising the children. The BF was not home at the time of the incident.
One of the siblings notified the PGM of the incident, who then went to a neighbor's home and called 911. EMS and law enforcement responded to the scene. The SC was brought to the hospital and was pronounced deceased at 3:35pm. Law enforcement investigated the incident and ultimately closed their case without arrest. The family declined to allow a full autopsy to be performed per their cultural beliefs, however did allow the medical examiner to conduct X-rays and a physical examination. An External Examination Report was issued which listed the cause of death as Basilar skull fractures due to blunt force trauma. Manner of death was as listed as accident.
The SC's death was the second fatality in three years within the family. On 7/1/13, a then three-year old sibling was killed after a 100 lb. cattle gate he was playing on tipped over and crushed his throat. Allegations of DOA/Fatality, IG, and LSUP were substantiated against the mother and father and that case was indicated and closed on 12/19/13.
JCDSS conducted a thorough investigation into the fatality that was the focus of this review. JCDSS assessed the surviving siblings as being safe in their home following several discussions and a safety plan with the adults around the need for appropriate supervision at all times. JCDSS offered services to include opening a preventive case and bereavement counseling, all of which were declined by the family. Although the family was reluctant to work with JCDSS and there were significant language and cultural barriers, JCDSS was able to conduct a full investigation by utilizing strong engagement skills and enlisting the assistance of informal family supports.
JCDSS substantiated allegations of DOA/Fatality and LSUP against the SM and PGM with regard to the SC, as it was determined that neither was providing an appropriate level of supervision to the SC which resulted in his death. The BF was determined to have no role in the fatality as he was not home at the time the incident occurred. The case was indicated and closed on 7/7/15. OCFS review found that casework activities were conducted appropriately,

however a Family Court - Article 10 petition was required and discussed but not filed. Further, allegations of LSUP and IG should have been added and substantiated regarding the four surviving siblings who were playing in the cart with SC, as well as IG related to the SC directly.

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:
Sufficient information was gathered to determine the allegations in the investigation.

Was the decision to close the case appropriate? No

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:
Due to the history of two fatalities within three years due to lack of supervision, Family Court action should have been pursued when the family declined to participate in preventive services, as there were twelve surviving children of various ages remaining in the household.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Allegations of IG and LSUP should have been added and substantiated against the adult caretakers regarding the four surviving children who were playing in the cart along with the SC. Allegation of IG should have also been added regarding SC.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	JCDSS will develop a plan to insure that appropriate allegations and subsequent determinations are included in CPS reports prior to their closure.

Issue:	Assessment as to need for Family Court Action
Summary:	Based on previous CPS/fatality history and current case circumstances, a Family Court (Article 10) petition was required but not filed.
Legal Reference:	18 NYCRR 432.2(b)(3)(vi)
Action:	JCDSS will develop a plan to insure that Family Court intervention is sought when the protective factors in a CPS case necessitate this level of involvement.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/19/2015 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 03:15 PM

County where fatality incident occurred: JEFFERSON
Was 911 or local emergency number called? Yes
Time of Call: 03:29 PM
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? No - but needed
At time of incident supervisor was: Unknown if they were impaired.

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	Male	9 Year(s)
Deceased Child's Household	Father	No Role	Male	36 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	72 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	72 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)

LDSS Response

JCDSS appropriately coordinated with law enforcement to conduct their investigation. Caseworkers adequately assessed the safety of the surviving siblings within an appropriate timeframe and established a safety plan with the family around supervision. JCDSS successfully identified and navigated cultural and language barriers and ultimately engaged the family to a degree that safety and risk could be assessed on an ongoing basis throughout the investigation. Caseworkers conducted global assessments that identified no additional safety factors outside of the supervision concerns.
There was evidence of frequent and detailed supervisory consultation throughout the case that involved all administrative levels. JCDSS' Legal Dept. was also consulted around case determination decisions. Informal supports were contacted and enlisted to assist in engaging the family. Additional collateral contacts included the medical examiner, other law enforcement agencies and first responders.
Preventive and other services were offered to the family but declined. Discussions were held with the family around seeking out their own supports in their community if needed. JCDSS provided the family with a written copy of their safety plan around supervision at the conclusion of the investigation.

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Jefferson County does not have a CFRT.

SCR Fatality Report Summary

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

			Outcome
024141 - Deceased Child, Male, 9 Yrs	024181 - Grandparent, Female, 72 Year(s)	Lack of Supervision	Substantiated
024141 - Deceased Child, Male, 9 Yrs	024182 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated
024141 - Deceased Child, Male, 9 Yrs	024181 - Grandparent, Female, 72 Year(s)	DOA / Fatality	Substantiated
024141 - Deceased Child, Male, 9 Yrs	024182 - Mother, Female, 37 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
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 safety 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 and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/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	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	☐	☐	☐	☐	☐	☒	☐

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:
Bereavement counseling and other services were offered to the family but declined. Discussions were held with the family regarding informal supports the family could utilize within their own extended family and culture/community.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement counseling and other services were offered to the family but declined. Discussions were held with the family regarding informal supports the family could utilize within their own extended family and culture/community.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
07/02/2013	7261 - Sibling, Male, 3 Years	7262 - Father, Male, 30 Years	DOA / Fatality	Unfounded	No
	7261 - Sibling, Male, 3 Years	7262 - Father, Male, 30 Years	Inadequate Guardianship	Indicated	
	7261 - Sibling, Male, 3 Years	7262 - Father, Male, 30 Years	Lack of Supervision	Indicated	
	7261 - Sibling, Male, 3 Years	7263 - Mother, Female, 30 Years	DOA / Fatality	Unfounded	
	7261 - Sibling, Male, 3 Years	7263 - Mother, Female, 30 Years	Inadequate Guardianship	Indicated	
	7261 - Sibling, Male, 3 Years	7263 - Mother, Female, 30 Years	Lack of Supervision	Indicated	

Report Summary:
Fatality report concerning the death of a sibling of SC.

On 7/1/13 the mother and father failed to adequately supervise 3-year old sibling. Sibling was outside playing on or near a cattle gate which fell over onto his neck, crushing his throat. The sibling was found by two other siblings who tried to lift the 100 lb. gate but were unable to.

Determination: Indicated | **Date of Determination:** 12/19/2013

Basis for Determination:
Some credible evidence was found indicating that the mother and father failed to supervise the sibling which resulted in the sibling's death. Allegations of IG and LSUP were substantiated and DOA/Fatality was unsubstantiated.
No explanation was provided in the investigation conclusion as to why the DOA/Fatality was not substantiated.

OCFS Review Results:
Safety and risk to the surviving siblings were adequately assessed. Casework activities were appropriate.

This report was previously reviewed by OCFS - SY-13-032. A Required Action was included in the report as JCDSS had unsubstantiated the DOA/Fatality allegation although there was some credible evidence to prove the allegation. A Corrective Action plan was developed with JCDSS to address this issue.

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

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

There is no known CPS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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

Additional Local District Comments

As a result of the family's cultural and religious beliefs, this case was very difficult and there were multiple consultations throughout the case involving JCDSS Administration, the JCDSS fatality review team, JCDSS Lead Attorney, Regional Office Staff, OCFS Attorney, a college professor considered an expert in the field pertaining to the specific cultural and religious beliefs, and a neighboring county with a large population of these individuals. Family Court action was discussed at length throughout the life of the case. This was a very devastating and unfortunate accident. A safety plan was put in place and Family Court Action would have done nothing more than create an environment of distrust and non-compliance with this family and the family's local community.

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