Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-23-051

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

Issue Date: Feb 02, 2024

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Jurisdiction: Suffolk
Date of Death: 08/24/2023
Age: 5 year(s)
Gender: Male
Initial Date OCFS Notified: 08/24/2023

Presenting Information

Suffolk County Department of Social Services received an SCR report which alleged on 8/23/2023, the 5-year-old subject child was not being adequately supervised and fell into the family pool. The subject child required a higher level of supervision due to his developmental needs. The subject child was transported to the hospital where he died the next day.

Executive Summary

This fatality report concerns the death of a 5-year-old male subject child that occurred on 8/24/2023. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against both the subject mother and subject father, and the allegation of Lack of Supervision against the subject mother regarding the subject child. At the time of this death, the subject child resided with his mother, father, and 4 and 16-year-old surviving siblings. There were 10- and 13-year-old paternal siblings from a previous marriage who did not live in the home but visited. The subject father had prior CPS history.

Suffolk County Department of Social Services (SCDSS) collaborated investigative efforts with law enforcement and learned that on 8/23/2023, the subject child was at home with the subject mother while the father was admitted to the hospital due to health concerns. The mother was outside on the deck attached to the house, pressure washing a rug. The subject child was outside on the deck with the subject mother. While the subject mother washed the rug, the subject child wandered to the family pool that had been installed approximately one month prior. The subject mother looked up from washing the rug and did not see the subject child. The mother immediately ran to the pool where she found the subject child lifeless, at the bottom of the pool. The mother jumped into the pool and retrieved the child and then ran him inside the home and screamed for someone to call 911. The 16-year-old surviving sibling ran to the mother, dialed 911 and started CPR while the subject mother ran to seek help from a neighbor who was an emergency responder. The neighbor and subject mother ran to the home and took over CPR until other emergency responders and the police arrived. The child was transported to the hospital where he remained on life support until the next day when he died. At the time of the incident, the 16-year-old went to the hospital with the mother and subject child, and the 4-year-old sibling went to a neighbor's home. When the subject child arrived at the hospital, the father, who was already at the hospital, joined the subject mother, 16-year-old sibling, and subject child in his hospital room.

An autopsy was performed, and the cause and manner of death were pending at the time this report was written; however, the Medical Examiner reported the subject child did not present with any injuries to his body. Medical records from the emergency room revealed the child had a diagnosis of drowning with cardiac arrest. The child remained on a ventilator until his death. Law enforcement conducted a criminal investigation and although the investigation remained open at the time this report was written, the record reflected there would be no criminal charges unless the final autopsy suggested criminality.

SCDSS substantiated all allegations and indicated the investigation against both parents. The record reflected the parents did not install a door alarm going out to the pool and the gate allowing entry to the pool did not have a self-closing latch. The subject mother did not provide the level of supervision consistent for a child with developmental delays. The 4 and 16-year-old siblings living with the subject child were assessed to be safe in the care of the subject mother and subject father. The 10 and 13-year-old paternal siblings were assessed to be safe in the care of their mother, whom they lived with.

PIP Requirement
SCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the LDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS will review the plan and revise as needed to address ongoing concerns.

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 determination was made in congruence with the evidence gathered.

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:
There was detailed documentation in the case record of supervisory consult and the decision to close the case was made commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	The SC had multiple PIDs that were never merged in CONNECTIONS.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	SCDSS records must contain information that is relevant, useful, factual and objective to best reflect

	accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/24/2023 **Time of Death:** 09:58 AM

Date of fatal incident, if different than date of death: 08/23/2023
Time of fatal incident, if different than time of death: 04:30 PM

County where fatality incident occurred: Suffolk
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 and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

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	5 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	44 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	44 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)
Other Household 1	Other Adult - Mother to 10yo SS & 13yo SS	No Role	Female	43 Year(s)
Other Household 1	Sibling	No Role	Female	13 Year(s)
Other Household 1	Sibling	No Role	Male	10 Year(s)
Other Household 2	Other Adult - Father to 16yo SS	No Role	Male	48 Year(s)

LDSS Response

Upon receipt of the initial SCR report on 8/23/2023, SCDSS initiated their response within 24 hours and coordinated their investigation with law enforcement. SCDSS received a subsequent report on 8/24/2023 when the child died and continued their investigation. SCDSS spoke with collateral contacts, interviewed family members, and immediately assessed the safety of the SSs.

SCDSS interviewed the parents and learned that on 8/23/2023, the SM was at home with the SC, 16yo SS and 4yo SS. The SF was admitted to the hospital at the time due to an unrelated medical concern. The SM was outside on the deck which was attached to the house with the SC. The large deck had a few stairs that led down to a smaller deck, blocked by an easily opened gate door, with an above-ground pool attached. The SM was pressure washing a rug on the top larger deck while the SC watched right next to her. The 4yo SS was inside on the couch watching television and the 16yo SS was in her bedroom. While pressure washing, the SM looked up to check on the SC and did not see him. The SM immediately ran to the pool and found the SC's body submerged at the bottom of the pool. The SM jumped in, grabbed the SC and then ran him into the home. The SM screamed for the 16yo sibling to call 911. The sibling ran to where the SM and SC were, called 911 and then started CPR while the SM ran to ask for help from the next-door neighbor, who was a first responder. The neighbor and SM ran back to the home and the neighbor took over CPR until other EMS and police arrived. The child was transported to the hospital. The mother and 16yo SS went with the SC and the 4yo SS went to a neighbor's home. The SF was alerted of the SC's pending arrival to the ER, and he was discharged from the same hospital to be with the SC. The child was pulseless until he arrived at the hospital where a pulse was recovered, and the child was placed on life support. The child was then airlifted to a hospital better equipped to meet his needs shortly after arriving at the ER. Medical records reflected the child suffered an anoxic brain injury and was in cardiac arrest for approximately 45 minutes. The child was noted to have been submerged at the bottom of the pool for approximately less than 5 minutes before the mother found him. Despite lifesaving efforts, the child died on 8/24/2023 at 9:58AM.

The record reflected SCDSS made collateral contacts to the town inspector regarding guidelines for required safety measures related to home pools and installation. SCDSS learned that the SM and SF failed to install a door alarm to the door going out to the pool from the home and the latch from the deck to the pool was not self-latching. Both of these safety precautions were a requirement based on the circumstances of the pool on the property. The record reflected that the SC was born premature at 26 weeks gestation and as a result had significant health problems at birth which resulted in him having a developmental disability requiring a higher level of supervision.

SCDSS learned that the SC was healthy and up to date with his immunizations and well-child visits. There were no concerns noted for the SSs and they were all assessed to be safe in the care of their respective caregivers. SCDSS filed a violation with the town for the pool not meeting town code regulations; that investigation was pending at the time this report was written. The family installed an additional latch on the pool gate. The family was offered fatality-related services, and the case was indicated and closed on 10/20/2023.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
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? No
Comments: SCDSS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065694 - Deceased Child, Male, 5 Year(s)	065696 - Mother, Female, 44 Year(s)	DOA / Fatality	Substantiated
065694 - Deceased Child, Male, 5 Year(s)	065696 - Mother, Female, 44 Year(s)	Inadequate Guardianship	Substantiated
065694 - Deceased Child, Male, 5 Year(s)	065696 - Mother, Female, 44 Year(s)	Lack of Supervision	Substantiated
065694 - Deceased Child, Male, 5 Year(s)	065697 - Father, Male, 44 Year(s)	DOA / Fatality	Substantiated
065694 - Deceased Child, Male, 5 Year(s)	065697 - Father, Male, 44 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐

At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☐	☐	☒	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Explain as necessary:
No children needed to be removed as a result of 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	Offered,	Offered,	Not	Needed	N/A	CDR

	After Death	but Refused	Unknown if Used	Offered	but Unavailable		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?	Yes
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)	Allegation Outcome	Compliance Issue(s)
03/11/2021	Sibling, Male, 8 Years	Father, Male, 42 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
An SCR report dated 3/11/2021 alleged the SF disciplined the then 8yo half-SS by hitting him with a belt and/or punching him.

Report Determination: Unfounded | **Date of Determination:** 05/06/2021

Basis for Determination:

SCDSS interviewed the SSs who reported no concerns for the care provided by the SF. The SF denied using corporal punishment on the children and the children did not present with marks or have a fear of their father. The case was closed and unfounded.

OCFS Review Results:
SCDSS interviewed the two half siblings, then ages 8yo and 11yo, their mother (PS) and the BF. The record did not reflect the SM was interviewed and the allegations were not addressed with her, despite the alleged incident having happened in her and the SF's home. The RAP was not completed accurately.

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

Issue:
Adequacy of Risk Assessment Profile (RAP)
Summary:
SCDSS became aware through interviews that the SF and PS had a history of domestic violence; however, the RAP did not reflect that.
Legal Reference:
18 NYCRR 432.2(d)
Action:
SCDSS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
SCDSS did not interview or observe the SC and SSs living with the SF, despite him being an alleged subject. In addition, the record did not reflect an interview with the SM.
Legal Reference:
18 NYCRR 432.1 (o)
Action:
SCDSS will incorporate key safety-related questions as they pertain to case circumstances. The victim child(ren) and every other child in the household should be interviewed prior to closing the investigation.

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

In 2018, there was one unfounded CPS investigation alleging inadequate guardianship of the then 5yo and 8yo half-SSs and excessive corporal punishment of the then 5yo SS against the SF. Concerns were that the father was becoming aggressive with the children and losing his temper. The SC had no role.

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