Child Fatality Report

Report Identification Number: SV-17-035

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

Issue Date: Nov 21, 2017

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: 2 year(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 08/26/2017
Initial Date OCFS Notified: 08/27/2017

Presenting Information

An SCR report was received regarding the death of the 2-year-old SC. The report alleged that on 8/23/17,while at the MA's home, the SM failed to supervise the SC. As a result, the SC went missing and was found floating in a swimming pool. The SM called 911 and the MA and EMS responded. EMS performed CPR on the SC and transported her to the hospital. The SC was pronounced brain dead on 8/26/17.

Executive Summary

This report concerns the death of a 2-year-old female that occurred on 8/26/17. Suffolk County Department of Social Services (SCDSS) received a subsequent SCR report regarding the fatality. The report alleged that the SC wandered into a swimming pool at her MA's home because the SM was not supervising her. The SC was in the pool for at least 10 minutes and was pulled out by the MA's mother-in-law. The SC was taken to the hospital and placed on life support. Hospital staff performed brain testing and found the SC had no brain activity. The death of the SC was pronounced at the hospital. At the time of the report concerning the SC's death, SCDSS had an open CPS investigation, based on an SCR report they received on 8/23/17. The 8/23/17 SCR report alleged the SC fell in a pool and was hospitalized as the result of the accident. The SC was an otherwise healthy child and was not known to take any medication.

The cause and manner of death of the SC were pending at the time this report was written. The ME performed an autopsy of the SC and reported there were no signs of trauma or abuse , and she appeared to be a healthy child. The ME told SCDSS that it is possible the SC was only in the pool for 10 minutes. The ME did not provide any further information to SCDSS, and stated the final autopsy would be completed in a few months.

LE investigated the death of the SC and reported there was no evidence of criminality. LE interviewed the SM and BF and found them to be appropriate and cooperative. The LE investigation remained open at the time this report was written, pending the final autopsy results.

During the investigation, SCDSS spoke with the MA, SM and 8yo CH of the MA. All of these individuals were present at the time of the fatal incident. The MA's mother-in-law was also present. SCDSS asked the MU for her contact information, because she had returned to her country when the death occurred. The MU did not provide that information, because he stated his mother was hospitalized due to the trauma seeing the SC in the pool and retrieving her from it. The MA and MU's 10yo CH, MU and BF were not present at the time of the incident, but they were also interviewed. All adults and CHN were spoken to about water safety. The two CHN denied they ever went near the swimming pool in the back yard. SCDSS contacted the SC's pediatrician and daycare provider. There were no concerns noted by anyone regarding the care the SM and BF provided to the SC.

SCDSS observed the swimming pool and backyard during their investigation. The pool was surrounded by fences and safeguarded with a gate.

SCDSS made the appropriate determination to unsubstantiate the allegations of DOA/Fatality, IG and LS against the SM regarding the SC. SCDSS learned through interviews that the SC rarely visited the MA and MU's home. When the SC was there she never expressed the desire to go in the backyard into the pool and swim, and she never left the house without supervision. On the day of the fatal incident the SM was helping the MA put away groceries in the kitchen and saw the SC in the living room with the 8yo CH. The SM noticed the SC was gone within 10 minutes and acted appropriately after that

realization. It was not common for the SC to wander off and the events were a tragic accident.

SCDSS offered the SM,BF, MA, MU and the 8yo and 10yo SC bereavement counseling referrals and grief assistance. The offers were refused because the family had a tremendous amount of support within their family and community.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

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 were no surviving children and closing the case was appropriate.

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: 08/26/2017 **Time of Death:** 02:19 AM

Date of fatal incident, if different than date of death: 10/23/2017
Time of fatal incident, if different than time of death: 03:45 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 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? 10 Minutes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

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

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Father	No Role	Male	31 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)

LDSS Response

Upon receiving an SCR report on 8/26/17 SCDSS began investigating the fatality. SCDSS interviewed the SM, MA, BF, MU and the MA's CHN (ages 10 and 8). SCDSS contacted the ME, LE and the DA. SCDSS learned that on 8/23/17, the SM and SC had been visiting the MA's home. The MA resided in a basement apartment of a house with the MU and their 10yo and 8yo CHN. The SM and BF lived in their own apartment with the SC. The SC had no SS.

The SM and MA both reported they had taken the SC to the store to do food shopping for a party later that day. The MA's mother-in-law was returning home after visiting for 2 months and the family was gathering to celebrate. The MA's mother-in-law and 8yo CH stayed home while they went shopping. The MU and 10yo CH were not home because they were running errands. The BF of the SC was at work on that day. The SM, MA and SC arrived home from the store about 4:00PM and the SM and MA began putting the food away in the kitchen while the SC played with the 8yo CH in the living room of the apartment. The SM and MA both stated about 10 minutes passed and the SM noticed the SC was no longer playing with the 8yo. The SM began asking where the SC was, but no one knew. The MA and SM went outside to the front of the home and began calling the SC's name. The MA was panicked and then called the MU and he called 911 to report the SC missing. They then heard screaming coming from the backyard and ran toward it. When they arrived in the backyard the MA's mother-in-law was pulling the SC from the above ground swimming pool. The SM began crying and the MA attempted to resuscitate the SC with CPR. The SC was observed to have foam coming from her mouth and water coming out of her nose. The police arrived minutes later and began CPR until EMS arrived and took over. The SC was

taken to the ER in an ambulance and the SM followed in LE's car. The SC was resuscitated and intubated and then admitted to the hospital. All parties denied alcohol/drug use.

Medical staff performed two brain death exams, 12 hours apart and found the SC had no brain-stem function. The SM and BF to discontinue life support and the SC was declared deceased on 8/26/17 at 1:22AM.

SCDSS interviewed the 8yo CH that was present at the home when the SC was found in the pool. The 8yo confirmed the SM and MA had been at the store with the SC, the MU and 10yo were out and she was home with the mother-in-law. The CH remembers the SC being in the living room with her and did not remember the SC walking outside. The CH stated that they were not allowed in the backyard. SCDSS also interviewed the 10yo CH. He had no knowledge of what occurred the day of the fatal incident. The 10yo CH also reported that the SC, 8yo and himself were not permitted to go in the backyard at any time.

LE said the mother-in-law was interviewed before she left and reported the same events as the SM and MA.

The owner of the home (OA) where the MA and MU resided and the fatality occurred was also interviewed. The OA stated that it was known that the pool and backyard were not to be used by the occupants of the basement apartment, and he had never seen the 8yo, 10yo or SC in the backyard previous to the fatal incident. The OA was inside his home and heard screaming from the backyard. The OA looked outside and saw someone attending to the SC and immediately concluded the SC had been in the pool. SCDSS observed the pool and backyard area and took pictures. The perimeter of the pool had fencing around the top of it and the only access was to use a ladder leaning against it. SCDSS observed the entire backyard was enclosed by fencing and the only way to get to the pool was by opening a gate. The SC was not tall enough to open the gate and it was surmised the SC squeezed through the fence in order to access the pool. The OA reported the Town had come and looked at the home and he would receive citations for tenants in an illegal apartment, not the pool.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical 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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041924 - Deceased Child, Female, 2 Yrs	041925 - Mother, Female, 30 Year(s)	Lack of Supervision	Unsubstantiated
041924 - Deceased Child, Female, 2 Yrs	041925 - Mother, Female, 30 Year(s)	Inadequate Guardianship	Unsubstantiated
041924 - Deceased Child, Female, 2 Yrs	041925 - Mother, Female, 30 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

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

Services Provided to the Family in Response to the Fatality

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

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? 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? N/A
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)
08/23/2017	Deceased Child, Female, 2 Years	Mother, Female, 30 Years	Lack of Supervision	Unfounded	No

Report Summary:
An SCR report was received on 8/23/17. The report alleged the SM failed to provide adequate supervision for the SC (age 2). The SC was left unattended, went outside and went into the pool. The SC drowned in the pool, was revived and is was in a medically induced coma. It was unknown if the SC was going to survive.

Determination: Unfounded | **Date of Determination:** 10/16/2017

Basis for Determination:
The incident occurred at the MA's home. The SC and SM were there for a party. The SC wandered into the back yard where the pool was, and the SM began searching for her after about 10 minutes of not seeing her. The pool did not belong to the MA, it belonged to the landlord. The MA and her children were not permitted to go in the backyard where the pool was located. The SC had regularly visited the MA's home.

OCFS Review Results:
The allegations of the report were investigated concurrently with the fatality investigation. The casework was commensurate with the circumstances.

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 CPS history more than 3 years prior to the fatality.

Known CPS History Outside of NYS

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

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.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Foster Care Placement History

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

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No