Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-20-066

Prepared by: New York City Regional Office

Issue Date: Dec 17, 2020

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: 6 year(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 07/14/2020
Initial Date OCFS Notified: 07/15/2020

Presenting Information

The 7/15/20 report alleged on 7/11/20, the SM did not provide adequate supervision of the SC. The SM and SC were at a party in Westbury, NY. The SM went to the bathroom, leaving the SC unsupervised. The SC went towards the pool with several unknown CHN. The SC fell into the pool and drowned. The SC was resuscitated by Emergency Medical Technician (EMT) and brought to the hospital where he remained in critical condition until 7/14/20, when it was believed he succumbed to his injuries.

Executive Summary

The 6-year-old male child (SC) died on 7/14/20. As of 12/17/20, NYCRO had not yet received a copy of the autopsy report.

At the time of the SC's death, the family had an open ACS investigation that was registered on 7/11/20. On 7/15/20, ACS was in the process of investigating the report when the SCR registered a report that included the allegations of DOA/Fatality, IG and LS of the SC by the SM. Nassau County Department of Social Services (NCDSS) was assigned secondary responsibility on the report; the incident and death occurred in Nassau County.

ACS learned that on 7/11/20, the SM and SC arrived at the hotel located in Long Island to attend a party that the SM's friend organized for her 8-yo CH. According to the SM, her friend reserved two rooms at the hotel. When she and the SC arrived at the hotel, the other party guests were in the pool. The SM did not know the guests with the exception of her friend and her friend's 16-yo female and 8-yo male CHN. All the guests went to the third floor, which was where the rooms were located. The CHN shared one room and the adults were in the adjacent hotel room. The SM prepared the SC with his swimsuit, left him with the other CHN and entered the adult room to prepare for the pool. The SM was in the adult room for approximately 15 minutes and when she exited the room the CHN were no longer in the adjacent room. When the adults and SM saw the CHN were not in their room, the SM took the elevator to the first floor where the pool was located to find the SC. As she approached the pool room, she saw the SC on the floor. He was wet, and she attempted to administer CPR with the assistance of an adult female who was in the room at the time. The SC vomited water but was unresponsive. The 911 operator was contacted as well as an emergency medical technician (EMT).

According to the BF, the SM contacted him by phone and said the SC accidentally fell in the pool and was transported to the hospital. The SC had no siblings and there were no other children in the SM or BF's household. The BF said he had a visitation agreement with the SM and he described the SM as a responsible caretaker for the SC.

On 7/30/20, the SM informed ACS she did not need counseling or bereavement services as she had her family for support. ACS attempted to assist the family with burial arrangements.

On 9/9/20, the Nassau County ME reported the preliminary findings showed the SC was submerged under water due to accidentally drowning. The autopsy report was not completed and would take more than five months.

As of 12/17/20, ACS had not yet made a determination on the fatality report.

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?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

Explain:
NA

Was the decision to close the case appropriate? N/A
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:
NA

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: 07/14/2020 **Time of Death:** 04:10 PM

Date of fatal incident, if different than date of death: 07/11/2020
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Nassau
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? N/A
Child's activity at time of incident:

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

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:

- ☐ 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	Male	6 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Other Household 1	Father	No Role	Female	29 Year(s)

LDSS Response

On 7/15/20, LE reported the SM said she left the SC in the room with the other CHN and went next door to the adult room to prepare for the swimming pool. She stated that she was in the adult room for about 15 minutes and when she and the other adults exited, the CHN were no longer in their room. Once the adults saw the CHN were missing from their room, they went to the elevator and they met the 16-yo CH who said the SC did not want to go in the pool. The SM approached the pool area and saw the SC on the floor near the pool. LE explained that there was no evidence to determine how many individuals were in the pool at the time of the incident.

On 7/15/20, the SM's friend, who was interviewed by phone, told ACS she reserved two rooms on the third floor of the hotel from 7/10/20 to 7/12/20 to have a party for her 8-yo male CH. According to the friend's account, all the CHN shared one room while the adults were in an adjacent room. The CHN who attended the event were the SC, the friend's 8-yo and 16-yo CHN, her 4-yo niece, 17-yo cousin and two other CHN. There were seven adults at the event including the friend. The friend explained that she was not familiar with two of the adults and was not willing to involve the other family members or friend in the ACS investigation. The friend said all the adults were together when the incident occurred. They were in the room preparing for swimming in the pool while the CHN were in the room next door. She told the CHN not to go into the pool. It took about 10 minutes to prepare for the pool and when they exited the room the CHN were no longer in their room. They took the elevator to the first floor and saw someone who stated someone's CH was drowning. They went quickly to the pool room and saw the SC on the floor near the pool.

The friend's 16-yo CH said the other CHN went to the pool together and she went down a minute or two later. The adults were in their room, and she went to the pool, retrieved her niece and cousin and returned with them to children's room. As she left, she heard the 8-yo CH ask her 17-yo cousin to get in the pool with the SC, but the SC did not want to enter the

pool. She went upstairs with the her niece and nephew and saw the adults exiting the adult room. Later, they went downstairs, and saw the SC on the floor near the pool area. She said she believed the SC either slipped or fell in the pool. She said the SC was found in the four-foot section.

The 8-yo CH said when the adults entered their room, he went to the pool with the other CHN. He said his 16-yo sibling stayed in the room. When they went to the pool room there were other people in the pool. He said he looked away for 30 minutes as he was playing in the pool. He said another CH started pulling the SC out of the pool while a female CH helped.

On 7/16/20, NCDSS interviewed the hotel personnel, who said there were no hotel personnel in the pool room and hotel personnel did not witness the incident. The documentation showed the hotel became aware of the incident when an unidentified person knocked by the lobby doors informing the personnel that the SC was found submerged in the pool. CPR was performed and 911 had already been contacted. NCDSS observed the pool and the room that the SC and SM occupied. The documentation showed an occupant needed a hotel key to access the pool area. There were signs displayed in the pool room that explained there was no lifeguard on duty, and the pool rules and warnings.

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)?No
Comments: The case documentation did not reflect there was an MDT response.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in NYC.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
055704 - Deceased Child, Male, 6 Yrs	055705 - Mother, Female, 26 Year(s)	DOA / Fatality	Pending
055704 - Deceased Child, Male, 6 Yrs	055705 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
055704 - Deceased Child, Male, 6 Yrs	055705 - Mother, Female, 26 Year(s)	Lack of Supervision	Pending

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?	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:
The documentation did not reflect family members such as the MGPs were interviewed.

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	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	☐	☐	☐	☐	☐	☒	☐

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? N/A
Explain:
There were no SSs or other CHN in the household.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS attempted to assist the family with burial arrangements.

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? N/A
Was the child acutely ill during the two weeks before death? Yes

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)
07/11/2020	Deceased Child, Male, 6 Years	Mother, Female, 26 Years	Inadequate Guardianship	Pending	Yes
	Deceased Child, Male, 6 Years	Mother, Female, 26 Years	Lack of Supervision	Pending	

Report Summary:
The report alleged on 7/11/20, the SC and SM were visiting a hotel for a party. The SC left the room alone and went to the pool. The SM was not aware he was missing. It was unknown how long the SC was gone, but he ended up in the

pool. He did not know how to swim. Around 6:30 PM, the SC was found unresponsive and in cardiac arrest. Emergency services revived him at the scene. However, he was still in critical condition. He was intubated, because he could not breathe on his own.

Report Determination: Undetermined

OCFS Review Results:
On 7/12/20, the hospital personnel told ACS the SC was admitted and in critical condition following an incident in which he was submerged in a hotel pool for an undetermined amount of time. The personnel said the SM was in one of the rooms when the SC, with some other CHN, including two teenagers, left their room and went to the pool. When the SM arrived at the pool she saw the SC lying unresponsive on the floor and someone performing CPR. The physician said the diagnosis for the SC was brain injury secondary to accidental drowning. Nassau County PD said the family was at the hotel for a party. LE said the pool was 4'6" all around and the water was murky. The SC died on 7/14/20.

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

Issue:
Contact/Information From Reporting/Collateral Source

Summary:
The documentation did not reflect the MGP's were interviewed. The SM reported living with the MGP's and identified them as her support system.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)

Action:
ACS must submit a PIP within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.

[redacted]

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

The SM was a subject in four reports dated 2/9/15, 4/9/15, 5/4/15, and 1/1/17.

The allegation of the 2/9/15 report was IG of the SC by the SM and BF. On 3/23/15, the report was IND and closed. The family received a referral for community-based services.

The allegations of the 4/9/15 report were C/T/S, IG and XCP of the foster CH by the SM (who was listed as an aunt). The allegations of the 5/4/15 report were IG, C/T/S and XCP of the CH by the SM (who was listed as an aunt). The 5/4/15 report was consolidated with the open investigation. On 6/8/15, ACS UNF the report and closed the case with no services required.

The allegation of the 1/1/17 report was IG of the CH by the SM (who was listed as an aunt) and parent substitute. On 3/2/17, the report was UNF. It was closed with no services required.

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