Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-19-025

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

Issue Date: Nov 22, 2019

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: 1 year(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 06/02/2019
Initial Date OCFS Notified: 06/02/2019

Presenting Information

An SCR report was received with concerns on 5/31/19, the grandparents were watching the one-year-old subject child in the living room of their home. At some point, the grandparents left the room and the child was unsupervised for an unknown period of time. While unattended, the child opened the door to the outside pool area and fell into the pool. The grandfather found the child face down and non-responsive. Emergency services were called and transported the child to the hospital, where she was placed on life support. The child died from her injuries on 6/2/19 at 11:45 AM.

Executive Summary

This fatality report concerns the death of a one-year-old female subject child (SC) that occurred on 6/2/19. A report was made to the SCR on that same date with allegations of Inadequate Guardianship, Lack of Medical Care and DOA/Fatality against the child's maternal grandfather (MGF) and maternal grandmother (MGM). Westchester County Department of Social Services (WCDSS) received the report and investigated the child's death. An autopsy was completed; however, the official report was not yet available at the time of this writing. Hospital staff noted the child died from cardio-respiratory arrest and hypoxic-ischemic brain injury due to drowning.

At the time of the child's death, she resided with her mother (BM), father (BF), and two siblings (SS), ages 9 and 7 years old. The investigation revealed the maternal grandparents would come to the family home each morning to babysit the child while the parents worked or had other obligations. On 5/31/19, the father was at work, the mother was at church, and the siblings were at school. The grandparents were caring for the child in the family home and sometime after lunch, the child was in the dining room with the grandfather playing. The grandfather left the room to use the bathroom and did not inform the grandmother, who was in the kitchen, he was leaving to do so; he was gone for approximately three minutes. Upon his return, the child was no longer in the dining room and neither he nor the grandmother knew where she was. After looking through the house, the grandparents noticed the back door to the home was open. The grandfather went outside and found the child face down and unresponsive in the family's inground swimming pool. The grandfather took the child out of the water and brought her inside. He began CPR while the grandmother contacted emergency services. The ambulance arrived shortly thereafter and transported the child to the hospital, where she was placed on life support. The child succumbed to her injuries and was declared deceased on 6/2/19.

From the time the investigation began to the time of its closure, WCDSS met with all family members and interviewed pertinent collateral sources. Law enforcement completed an investigation and their findings corroborated the information the family provided to WCDSS. There were no criminal charges brought against the grandparents. Although the surviving siblings were observed on more than one occasion, the record did not reflect WCDSS interviewed them regarding the day to day events in the home. WCDSS found evidence to substantiate the allegations against the grandfather due to him leaving the child unattended for several minutes and not informing the grandmother. WCDSS found no evidence to substantiate the allegations against the grandmother. The case was indicated and closed to community-based services.

PIP Requirement

WCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of issuance of this report. This PIP will identify what action(s) WCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, WCDSS will review the plan(s) and revise as needed to further address on-going 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:
WCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the surviving siblings.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Failure to Conduct a Face-to-Face Interview (Subject/Family)
Summary:	Although the record reflected the surviving siblings were observed and assessed to be safe, they were not interviewed. There was a missed opportunity to gather information as the siblings may have offered information pertinent to the investigation.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(a)
Action:	The full child protective investigation must include face-to-face interviews with subjects of the report and family members of such subjects, including children named in the report.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/02/2019 **Time of Death:** 11:54 AM

Date of fatal incident, if different than date of death: 05/31/2019
Time of fatal incident, if different than time of death: 02:00 PM

County where fatality incident occurred: Westchester
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? 4 Minutes
At time of incident supervisor was:

- ☐ Drug Impaired
- ☒ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	1 Year(s)
Deceased Child's Household	Father	No Role	Male	50 Year(s)
Deceased Child's Household	Mother	No Role	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Male	64 Year(s)
Other Household 2	Grandparent	Alleged Perpetrator	Female	65 Year(s)

LDSS Response

On 6/2/19, WCDSS received the SCR report regarding the death of SC, which occurred on that same date. WCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. WCDSS learned SC succumbed to her injuries after being hospitalized since 5/31/19, when she was found unresponsive in an inground swimming pool while in the care of her grandparents.

On 6/2/19, WCDSS completed a visit to the family's residence. WCDSS spoke briefly with BM, but BF was too upset to meet with the CWs. BM reported the incident as a "freak accident," and stated there had never been any concerns regarding the grandparents' ability to care for the CHN. BM stated the grandparents would care for SC at the home daily. BM stated on 5/31/19, BF was at work and she was at church when the incident occurred; the two SS were in school. BM stated all she knew was what the grandparents told her happened. BM stated she was informed MGM left SC and MGF in the dining room together and then MGF got up to use the bathroom. BM stated he told her when he returned from the bathroom, he did not see SC, and MGM did not know where SC was. MGF then saw the back door was open and he went to look outside for her. BM stated that is when MGF found SC in the pool. On this same date, WCDSS also spoke with an aunt (MA), who corroborated the events as told to BM. MA explained the grandparents spoke little English, and she translated for them when speaking to police. MA was not present for the incident, but accompanied MGM and MGF to the police station to provide statements. Both SS were observed at this home visit and assessed as safe. BM informed WCDSS the SS knew how to swim and not to enter the pool unsupervised.

On 6/4/19, BM informed WCDSS the family retained an attorney and all communication would need to go through him. On 6/27/19, WCDSS spoke with the town code inspector regarding residential pool codes and was informed there had been no violations for the pool at the case address.

On 7/24/19, WCDSS met with the family and their attorney at the Westchester County Attorney's Office. The MA was present as a translator for the grandparents. The parents explained the grandparents had taken care of the CHN since they were born, and that they would come to their home daily to do so. The grandparents were at the home from 7:00 AM to 5:00 PM, Monday through Friday. The parents reported the pool at the house had just been opened the week prior and the SS had swim lessons at a young age. BM stated she was not aware of any pool code regulations prior to SC's death, but had recently received a letter and would be putting a fence around the pool.

The grandparents were also interviewed on this date. They stated they arrived at the home at 7:00 AM on 5/31/19. At 10:00 AM, SC went down for a nap and awoke at 11:30 AM. MGF stated he was at the dining room table doing paperwork and MGM was in the kitchen. MGF said SC was moving around the house, playing, and looking at books. MGF stated he went to the bathroom, which was located on the lower level of the home and was in there for about 3 minutes. MGF stated when he returned to the dining room, he did not see SC and MGM did not know where she was; MGM was unaware MGF had gone to use the bathroom. The two saw a back door was open; the door was initially locked, and they were not aware SC knew how to unlock it. BM stated SC had never tried to open that door before. MGF stated he walked outside and found SC face down in the pool and he jumped in to retrieve her. MGF said he brought her in the house and began CPR while MGM called 911. SC was brought to the hospital where she was placed on life support until 6/2/19.

Throughout the investigation, WCDSS spoke with numerous collateral sources and offered the family appropriate services. LE found no criminality regarding SC's death. WCDSS found evidence to substantiate the allegations against MGF only and indicated and closed their case.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: This fatality investigation was conducted by the Westchester County MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: This fatality was reviewed by the Westchester County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051861 - Deceased Child, Female, 1 Yrs	051868 - Grandparent, Female, 65 Year(s)	DOA / Fatality	Unsubstantiated
051861 - Deceased Child, Female, 1 Yrs	051868 - Grandparent, Female, 65 Year(s)	Lack of Supervision	Unsubstantiated
051861 - Deceased Child, Female, 1 Yrs	051867 - Grandparent, Male, 64 Year(s)	DOA / Fatality	Substantiated
051861 - Deceased Child, Female, 1 Yrs	051867 - Grandparent, Male, 64 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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
WCDSS interviewed the parents, grandparents, and appropriate collateral sources. The record did not reflect attempts to interview the SS. Progress notes and other documentation were completed and entered timely.

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: Appropriate service referrals were given to the family in response to the death of SC.				

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?	☐	☒	☐	☐
Explain as necessary: There were no surviving children 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 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: Grief and bereavement service referrals were provided to the family in response to SC's death. The family was not in need of any additional services.							

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:
WCDSS offered the family appropriate services in response to SC's death.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS provided mental health referrals for family members to cope with the loss of SC.

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

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

Known CPS History Outside of NYS

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

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