Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-22-024

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

Issue Date: Dec 02, 2022

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	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:** Orange | **Date of Death:** 07/03/2022
Age: 8 year(s) | **Gender:** Male | **Initial Date OCFS Notified:** 07/03/2022

Presenting Information

Orange County Department of Social Services received an SCR report on 7/3/22 which alleged that at approximately 8:00PM, the subject child ran outside and jumped into the deep end of the pool. The child did not know how to swim and began to sink. The father, who also did not know how to swim, jumped in to save him. The father and child drowned. Emergency responders and hospital staff attempted to revive the child by performing CPR, administering epinephrine, and four rounds of defibrillation. The child did not regain consciousness, a pulse, or sinus rhythm and was pronounced dead at 9:35PM. The mother and father failed to adequately secure the pool which resulted in the child jumping into the pool and drowning. A subsequent report was registered regarding the same incident the following day.

Executive Summary

This report concerns the death of an 8-year-old child. Orange County Department of Social Services (OCDSS) received two SCR reports regarding the child's death, on 7/3/22 and 7/4/22. At the time of the child's death, he resided with his mother, father, and 4-year-old brother.

On 7/3/22, the family opened the backyard above-ground swimming pool for the first time and invited extended family over. The family was in and out of the pool all day, starting around 1:00PM. Sometime after 3:00PM, the family exited the pool to eat. After this, they returned outside, and the mother went into the pool alone while the father and children played basketball. At some point, the subject child and a 10-year-old family friend got back into the pool. When the mother got out of the pool, she told the father and a 16-year-old relative to watch the children. The subject child had his life jacket on when the mother went inside. The father was on the pool deck, and the 16-year-old was sitting with her feet in the pool. The mother reported being inside approximately 30 minutes when she heard commotion outside and observed the father, fully clothed, in the pool. She told the 16-year-old to call 911 and she jumped into the pool. The mother did not know how to swim and struggled in the water. The subject child's uncle used the pool skimmer to get the child to the shallow end and the uncle began CPR on the child. Emergency responders arrived and jumped into the pool to rescue the father. Both the subject child and his father were transported to the hospital. The subject child was pronounced dead at 9:35PM on 7/3/22 and the father was pronounced dead at 12:00AM on 7/4/22.

The medical examiner was notified of the fatality and performed an autopsy of the child. The final cause of death was drowning, and the manner of death was considered an accident. Law enforcement investigated and closed their investigation, citing the case being determined an accidental drowning. No criminal charges or arrests were made.

OCDSS made several home visits, interviewed the mother and uncle, completed CAC interviews with the children present during the incident, and observed the 4-year-old sibling, who was assessed safe in his mother's care.

OCDSS unsubstantiated the allegations against the mother and the now deceased father regarding the subject child. OCDSS supported unfounding the allegation of Inadequate Guardianship, based on collateral contacts and casework observations that the child's overall quality of care met minimum standards; medical and educational needs were being met and necessary provisions were provided within the home. Lack of Supervision was unfounded against the mother as she delegated supervision to the father and 16-year-old, which was confirmed through interviews. The decision to unfound the allegation against the father was made based on reports that he was on the pool deck, and both the subject child and 10-year-old child were on flotation devices and wearing life jackets while in the pool. The 10-year-old witnessed the

subject child remove his life jacket and slip under the water. The 10-year-old notified the 16-year-old first. Once the subject child went under the surface, he was not visible due to the cloudiness of the water. Through interviews, OCDSS concluded it did not appear to be a lengthy period of time before the father intervened, however, due to his death, he was unable to be interviewed. DOA/Fatality was unfounded as both parents made attempts to intervene, the mother provided appropriate safety measures with life vests, and OCDSS was unable to establish an accurate timeline to indicate how long, if at all, the child was not supervised.

The mother accepted bereavement services offered by OCDSS for the surviving sibling and had accessed her own counseling services prior to the investigation closing. The pool was immediately covered following the incident and subsequently removed from the yard.

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

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:

OCDSS interviewed relevant collaterals, adults, and all CHN present. The sibling's safety was assessed throughout the investigation. Fatality review meetings and supervisory consultations were held continuously. No service needs were identified to warrant ongoing child welfare intervention. The case was appropriately closed.

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: 07/03/2022 **Time of Death:** 09:35 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: 07:56 PM
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: swimming

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

LDSS Response

On 7/3/22 and 7/4/22, OCDSS received reports regarding the death of SC. OCDSS initiated their investigation within 24 hours and coordinated with LE. The sources of the reports were contacted, and a CPS history check regarding the family was completed. OCDSS assessed the safety of SS during an initial visit to the family at the hospital on 7/3/22 and a home visit on 7/4/22.

OCDSS interviewed the adults regarding the events leading up to SC's death. A timeline of the day was provided by SM. SM reported that the family moved into the home in February 2022 and the date of the incident was the first day they had used the pool. SF had invited his brother (PU) and PU's family to come use the pool. SM reported SC was aware of the pool rules. SC had taken swim lessons, had a life jacket to wear and there was a marker in the pool delineating the deep end. Around 1:00PM or 2:00PM, the family began to swim. It was learned no adult present knew how to swim well. Around 3:00PM they got out of the pool to eat. SM stated after this, she went into the pool alone while SF and the CHN played basketball. SC and a 10-year-old family friend (OC1) got back into the pool. At that time, SF was around the pool deck and PU's 16-year-old daughter (OC2) had her feet in the pool. SM got out of the pool and told SF and OC2 to watch

the CHN. SM recalled SC had his life jacket on when she left. SM was inside for approximately 30 minutes when she heard a commotion and saw SF fully clothed in the pool. SM told OC2 to call 911 and SM jumped into the pool. SM was unable to swim and struggled. PU's 14-year-old son (OC3) threw pool floats into the pool and PU used the pool skimmer to get SC toward the shallow end. LE and FD arrived and jumped into the pool for SF.

OCDSS interviewed PU and he provided a similar account of the day. PU was invited to the home by his brother, SF. He brought his CHN OC2 and OC3, and family friends OC1 and a 12-year-old (OC4). PU was unable to use the pool due to a motorcycle accident. PU confirmed his CHN knew how to swim. PU was inside the home when OC2 yelled for him. He went outside. PU used his crutch to help SM and the pool skimmer to help get SC out of the pool and he began CPR. SF remained in the pool. LE and FD arrived and took over CPR of SC and dove into the pool for SF.

OCDSS conducted CAC interviews with the CHN present during the fatal incident. OC2 stated she was at the pool side when SF asked where SC was. SF jumped into the pool to find SC. It is unknown how much time elapsed before SF noticed SC was not present. OC2 called 911. OC3 reported he was inside the home when OC2 came inside yelling. OC1 reported she was on the float in the pool when she saw SC take off his life vest. OC1 recalled cautioning SC not to take off the vest. SC went under the water, and OC1 got OC2's attention for help. No further questions of SF's whereabouts when SC removed his life jacket were documented to be asked of OC1. OC1 exited the pool when everyone was looking for SC. SS was not forensically interviewed. SS was observed on multiple occasions in the home and assessed safe. OCDSS learned at the initial home visit that the pool was covered immediately following the incident. PU and SM reported they were not allowing SS outside and OCDSS observed a lock on the double door leading out to the pool. OCDSS obtained photographs of the pool area from LE.

OCDSS spoke with ME, who was alerted to the situation prior to the SCR reports being made. The ME provided a final cause of death as drowning and recorded the manner of death as an accident.

OCDSS contacted numerous collateral sources, including the pediatrician, school, hospital and medical staff, family members, LE, ME, and MH. Bereavement services were offered to the family, and they accepted. At the close of the investigation, SS was engaged in counseling services and assessed safe. No criminal charges were brought, and the investigation was unfounded and closed.

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)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060901 - Deceased Child, Male, 8 Yrs	060902 - Mother, Female, 39 Year(s)	DOA / Fatality	Unsubstantiated

060901 - Deceased Child, Male, 8 Yrs	060902 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
060901 - Deceased Child, Male, 8 Yrs	060902 - Mother, Female, 39 Year(s)	Lack of Supervision	Unsubstantiated
060901 - Deceased Child, Male, 8 Yrs	060903 - Father, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
060901 - Deceased Child, Male, 8 Yrs	060903 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
060901 - Deceased Child, Male, 8 Yrs	060903 - Father, Male, 40 Year(s)	Lack of Supervision	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?	☒	☐	☐	☐

Additional information:

The father was listed as an alleged subject, however, he passed away 7/4/22 and was therefore unable to be interviewed.

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:
The family requested bereavement counseling referrals. OCDSS provided referrals and verified the SS was engaged in counseling services prior to closing the investigation. The mother was engaged in counseling services as well, which she accessed through her insurance provider. The RAP did not identify any other service needs and the mother denied needing any further assistance from OCDSS.

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?	☐	☒	☐	☐

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? Yes
Explain:
OCDSS provided a referral for bereavement counseling for the surviving sibling. OCDSS verified the sibling was engaged in counseling services prior to closing the investigation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
OCDSS offered to assist the mother with counseling services. The mother secured her own therapist through her insurance, who she was seeing twice weekly at the time of case closing. No other service needs were identified or requested.

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 investigative history more than three years prior to the fatality.

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