Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-21-021

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

Issue Date: Nov 09, 2021

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: 1 year(s)
Jurisdiction: Nassau
Gender: Male
Date of Death: 05/28/2021
Initial Date OCFS Notified: 05/28/2021

Presenting Information

Nassau County Department of Social Services (NCDSS) received an SCR report which stated on the morning of 5/5/21, the mother placed the subject child in the bathtub and closed the drain to fill the bathtub with water. The mother left the bathroom and left the child unsupervised in the bathtub. While the mother was out of the bathroom she read a message on her phone and accidentally fell asleep. The mother was awoken by water overflowing from the bathtub. The mother found the child in cardiac arrest in the bathtub. The subject child was hospitalized and removed from life support on 5/27/21. He passed away on 5/28/21 at 4:08PM.

Executive Summary

This fatality report concerns the death of a 1-year-old male child that occurred on 5/28/21. The child was listed on an open CPS case at the time of his death. The investigation began on 5/5/21, after an SCR report was received with concerns that the child drowned in the bathtub after the mother fell asleep, leaving the child unsupervised. The child was hospitalized and succumbed to his injuries on 5/28/21, after the parents removed the child from supportive care. A report was made to the SCR with allegations of DOA/Fatality and Lack of Supervision against the mother. The child lived with his mother, father and 3-year-old sibling and the sibling was assessed to be safe in the care of the parents.

On 5/5/21, NCDSS learned of the drowning of the subject child and immediately began gathering information related to the incident. It was determined that at the time of the drowning, the child was home with the parents and sibling. In the morning, the mother woke up with the children while the father slept. The child had a messy bowel movement, so the mother placed him in the bathtub and closed the drain. The mother left the bathroom to check on the sibling. The mother returned to the bedroom, checked her cell phone and fell asleep while sitting on her bed. When she woke up the tub was overflowing with water and the child was floating and blue. The father woke to the mother screaming. He called 911 and provided CPR at the instruction of 911 dispatch. First responders arrived and transported the child to the hospital.

The subject child was initially received by one hospital but then was transferred to another, where he was admitted to the intensive care unit. NCDSS regularly inquired with hospital staff regarding the medical status of the child. The child was intubated and was reported to have a poor prognosis. The child was eventually extubated; however, had limited brain activity. The parents decided to remove the child from all supportive measures on 5/27/21 and he passed away on 5/28/21.

An autopsy was performed; however, the results were not yet available at the time the CPS investigation was closed. The doctor who attended to the child reported his injuries were consistent with drowning. There were no other physical injuries to his body. NCDSS completed a joint investigation with law enforcement and the district attorney. There had been no criminal charges against the mother at the time this report was written. The criminal investigation remained pending and the the case would possibly be presented to a grand jury upon the mother's return to the country.

Following the fatality, the mother and sibling temporarily relocated to the mother's home country to be with relatives. The father remained in the country and NCDSS offered him grief counseling services. NCDSS gathered sufficient information to substantiate Lack of Supervision and DOA/Fatality against the mother. The investigation was indicated and closed on 7/23/21.

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?** No
  - **Safety assessment due at the time of determination?** No
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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:
Following the death, NCDSS attempted a home visit and learned that the mother and sibling had left the country. The mother did not have access to a telephone. NCDSS was not able to assess the sibling's safety following the death due to these circumstances. At the time the CPS investigation was closed the mother and sibling had not yet returned.

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:
Casework activity was commensurate with case circumstances.

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: 05/28/2021 **Time of Death:** 04:08 PM

Date of fatal incident, if different than date of death: 05/05/2021

Time of fatal incident, if different than time of death: 09:15 AM

Child Fatality Report

County where fatality incident occurred: Nassau
Was 911 or local emergency number called? Yes
Time of Call: 09:55 AM
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: Bathing

Did child have supervision at time of incident leading to death? Yes
How long before incident was the child last seen by caretaker? 35 Minutes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☒ Asleep
- ☐ 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	1 Year(s)
Deceased Child's Household	Father	No Role	Male	48 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

Upon receipt of the SCR report on 5/5/21, NCDSS initiated their investigation and coordinated efforts with law enforcement, notified the District Attorney and spoke to the source. NCDSS assessed the safety of the surviving sibling, who went to stay with the paternal grandmother following the death. It was determined he was safe remaining in the parents' care.

The father was interviewed and reported the night prior to the fatal incident he arrived home between 8:15PM and 8:30PM. The subject child was asleep when he arrived home. The mother and father watched a couple of movies together and went to sleep around 4:00AM. The subject child started crying around 7:00AM and the mother got him from his crib to breast feed him while in bed. The father woke to get the mother the IPAD to play music on and played with the child for a short time, and then went back to sleep. The father reported that he woke from a loud noise from something hitting the floor. The father reported he observed the mother on the floor of the bathroom, located in their bedroom. He started walking toward the bathroom and the mother came out holding the child in her arms and the child's skin was blue. The mother handed the child to the father and he shook the child to wake him. The mother attempted to initiate CPR but was doing it incorrectly and the father stopped her. The father called 911 and followed the instructions to perform CPR until

first responders arrived.

The mother did not speak English and was interviewed utilizing the language line translation service. The mother confirmed that on the morning of the fatal incident, she woke up with the children between 7:30AM and 8:00AM and went downstairs to feed them breakfast. The child had a bowel movement that went up his backside, so the mother bathed the child in their jacuzzi tub. While doing so, she left the room to check on the sibling. After checking on the sibling, the mother sat on her bed and stated she was able to see the child from her bed while she looked at her phone. The mother fell asleep and woke up around 9:50AM, saw the child and started screaming and retrieved the child from the bathtub.

NCDSS gathered information from first responders. The mother provided law enforcement with the same account of events that she reported to CPS. Law enforcement reported the incident appeared to be a case of negligence and a tragic mistake. Emergency medical services reported minimal contact with the family, but noted there was water damage to the first and second floor of the home. NCDSS documented efforts to gather records and speak with the child's pediatrician; however, records had not been received at the time of case closure. NCDSS called the children's pediatrician to follow up regarding the records and he did not express any concerns for the family.

The surviving sibling went to stay with the paternal grandmother after the subject child was hospitalized. The mother stayed at the hospital with the child and the father divided his time between the hospital and the grandmother's home. The sibling had a medical diagnosis that caused him to be non-verbal and he was unable to be interviewed. NCDSS completed several visual assessments of the child and his home environment. When the subject child passed away, the mother and sibling went to be with the mother's family in another country. The mother was unable to use her cellphone and communicated with the father via telegram. The father reported the mother was enrolled in counseling and the sibling was doing well. There was a tentative plan for the mother and sibling to return to the United States; however, it was unknown when that would happen.

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 reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: Nassau County indicated in their 24-hour and 30-day fatality reports that the fatality would be referred to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058276 - Deceased Child, Male, 1 Year(s)	058277 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
058276 - Deceased Child, Male, 1 Year(s)	058277 - Mother, Female, 28 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:
The surviving sibling was non-verbal and unable to to be interviewed. NCDSS observed the sibling on multiple occasions following the fatal incident.

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?	☐	☐	☒	☐

Explain:
Following the fatal incident on 5/5/21, NCDSS assessed the safety of the sibling and determined he was safe in the parents' care. Following the death, NCDSS attempted a home visit and learned that the mother and sibling had left the

country. The mother did not have access to a telephone. NCDSS was not able to assess the sibling's safety following the death due to these circumstances.

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:
Following the fatality, the mother and sibling left the country. NCDSS offered the father services regarding the fatality. NCDSS spoke with the father to determine if the mother and sibling were in receipt of necessary services in the country they were visiting and learned the mother was enrolled in counseling.

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? No
Explain:
The mother and sibling left the country following the fatality to be with relatives and were unable to be offered services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The father was offered grief counseling services. The mother was receiving counseling services where she was visiting.

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? No
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)

05/05/2021	Deceased Child, Male, 1 Years	Mother, Female, 2 Years	DOA / Fatality	Substantiated	No
	Deceased Child, Male, 1 Years	Mother, Female, 2 Years	Inadequate Guardianship	Substantiated	

Report Summary:
NCDSS received an SCR report which stated on 5/5/21 at 9:10AM, the mother prepared a bath for the subject child. While the child was in the bathtub with the water running, the mother went into the living room to check her phone. The mother laid down on the couch and fell asleep for approximately 45 minutes. When the mother woke up the tub was overflowing with water and the child was face down in the water. The mother screamed and the father woke up and ran down stairs. The father started chest compressions and 9-1-1 was notified. The child was intubated and on a ventilator. The child was in critical condition and at risk of death.

Report Determination: Indicated | **Date of Determination:** 06/30/2021

Basis for Determination:
NCDSS substantiated the allegations. It was determined that on 5/5/21, the mother placed the child in the bathtub with the water running and left the room to check on the sibling. The mother then sat down on her bed and fell asleep. The mother woke up to water overflowing in the bathroom and the child was floating in the tub. During the investigation, the child died while in the hospital and a subsequent report was called in.

OCFS Review Results:
NCDSS initiated their investigation within 24 hours of receipt of the SCR report. NCDSS completed home visits, conducted thorough interviews of the adults, searched SCR history and provided written notice of existence to the parents. NCDSS coordinated investigative efforts with law enforcement and the district attorney. The safety assessment tool and risk assessment profile were completed within required time frames and to accurately reflect the information obtained during the investigation. NCDSS collaborated with the assigned secondary county and supervisory consultation was documented throughout the investigation. The investigation was closed within the regulatory timeframe.

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

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