Child Fatality Report

Report Identification Number: SV-24-038

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

Issue Date: Feb 26, 2025

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 had an open investigation or a CPS monitored services 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
Age: 2 year(s)
Jurisdiction: Suffolk
Gender: Female
Date of Death: 09/07/2024
Initial Date OCFS Notified: 09/07/2024

Presenting Information

The SCR report alleged that on 9/7/24, at an unknown time, the mother failed to adequately supervise the four and two-year-old children who were missing for approximately thirty minutes. The mother looked for the children outside when a neighbor located them floating in a pond near the family's housing complex. Another adult pulled the children out of the pond. The adult and mother attempted cardiopulmonary resuscitation on the children while a neighbor called emergency medical services. After emergency medical services responded, the children were transported to the hospital at 3:53 PM and were pronounced deceased at an unknown time.

Executive Summary

This fatality report concerns the death of the 2-year-old female subject child that occurred on 9/7/24. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the mother. Allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision were added against the maternal grandmother. At the time of her death, the subject child resided with her mother, maternal grandmother, and 4-year-old sibling. The father lived out of the country.

Suffolk County Department of Social Services (SCDSS) completed casework and collateral contacts and learned that on 9/7/24, the mother was in her room with the 4-year-old and 2-year-old child while on a video chat with the father. The children wanted to play in the grandmother's room across the hallway and left the mother's room. A while later, the grandmother asked the mother where the children were. The mother said they were playing in the grandmother's room; however, the grandmother stated they were not there. The mother and grandmother began looking for the children and noticed the front door of the family's apartment was open and immediately went outside to look for the children. The mother got in her car and began driving around the apartment complex when she observed commotion by a pond in the complex. A bystander had located the 4-year-old child in the pond, retrieved her, and gave the child to the mother who began cardiopulmonary resuscitation. At this time, another bystander had located the 2-year-old child in the water on the other end of the pond, retrieved her, and began cardiopulmonary resuscitation on that child. Bystanders called 911 and emergency medical services responded and transported both children to the hospital where they were later pronounced deceased.

An autopsy was performed, and the final cause and manner of death were pending. Hospital staff and emergency medical services noted no injuries to either child. Emergency medical services noted the children must have been in the water a long time as they were cold to the touch, had wrinkled skin, had water in their airways, and the 2-year-old child had blood coming from her eyes. Law enforcement's investigation was ongoing, though they noted there were no suspicious findings and no charges were filed related to the children's death at the time of this writing.

Bereavement services were offered to the family; however, it was unknown if services were utilized. The allegations were substantiated against the mother and grandmother, as it was determined that the lack of supervision of the children contributed to their death. The case was indicated and closed on 10/31/24. There were no surviving children in the household.

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?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
SCDSS made an appropriate determination based on evidence obtained during their investigation.

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: 09/07/2024 **Time of Death:** 04:37 PM

Time of fatal incident, if different than time of death: 01:37 PM

County where fatality incident occurred: Suffolk

Was 911 or local emergency number called? Yes

Time of Call: 03:15 PM

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used and/or ingested alcohol or drugs? No

Child's activity at time of incident:

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

Total number of deaths at incident event:

Children ages 0-18: 2

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	73 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	42 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	4 Year(s)
Other Household 1	Father	No Role	Male	43 Year(s)

LDSS Response

Upon receipt of the SCR report, SCDSS initiated their investigation, coordinated their efforts with LE, completed a CPS history review, and interviewed household members.

SCDSS interviewed the SM and learned that on 9/7/24, the SM, MGM, and two children woke up around 10:30 AM and had breakfast. The SM spoke with the BF on video chat in the bedroom she shared with the two children. The children spoke with the BF but then got tired of talking and wanted to play in the MGM's room across the hallway. The SM continued to speak with the BF and reported that approximately 20 minutes later, the MGM came into the SM's room asking where the children were. The SM stated the children were in the MGM's room playing. The MGM stated they were not in her room. The SM and MGM began looking for the children and observed the front door of the family's apartment to be opened. The SM stated she immediately knew the children were outside and went outside to look for them. The SM stated she asked a few neighbors she passed if they had seen the children, but they had not. The SM returned to the home to get her phone and car keys and began driving around the apartment complex. The SM saw commotion by the apartment complex pond and got out of her car. The apartment complex's maintenance man located the 4yo child in the pond, got her out, and gave her to the SM, who began CPR. While performing CPR, the SM observed bystanders on the other end of the pond retrieving the 2yo child from the water. Bystanders began CPR on the 2yo child and multiple 911 calls were made by neighbors. EMS and LE responded and continued life-saving measures. The children were both transported to the hospital via ambulance where they were pronounced deceased.

The MGM corroborated the SM's version of events, though she noted she was unsure how long the children were gone for, as it was a blur. The MGM stated she was in the living room and then went into the kitchen to make the children lunch before checking in with the SM to see where the children were.

Video footage obtained by LE contradicted the SM's timeline. The video footage showed the two children leaving the family's apartment at 1:30 PM. The children were seen walking by neighboring apartments toward the pond, with the 2yo child ahead of the 4yo child. At 1:37 PM, the children were seen entering the pond. The SM and MGM were not seen leaving the apartment to look for the children until approximately 3:00 PM. The SM and MGM were asked about this discrepancy, and the SM denied it had been that long. The MGM stated she was unsure how long it had been but did not think it had been that long. The BF stated he was on video chat with the mother for 1 hour and 40 minutes.

The family resided in a second-story apartment. There was a baby gate at the top of the stairs leading to the family's apartment. The SM stated the children would go outside if the door was open but that the children could not open the door themselves. It was unclear how the front door of the apartment was opened and how the children bypassed the baby gate in the home. There was also a fence surrounding a portion of the pond. The SM and MGM denied ever going to the entrance of the pond the children accessed that day, stating they had been to the bridge that went over the pond but never the area where the children were located.

Collateral sources were contacted and denied any concerns for the SM or MGM's supervision of the children. Neighbors reported the children were always with the SM and MGM and never unsupervised. The SM denied the children had ever gotten out of the apartment before.

Official Manner and Cause of Death

Official Manner: Pending

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? No

Comments: Suffolk County does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070076 - Deceased Child, Female, 2 Year(s)	070078 - Mother, Female, 42 Year(s)	DOA / Fatality	Substantiated
070076 - Deceased Child, Female, 2 Year(s)	070078 - Mother, Female, 42 Year(s)	Inadequate Guardianship	Substantiated
070076 - Deceased Child, Female, 2 Year(s)	070078 - Mother, Female, 42 Year(s)	Lack of Supervision	Substantiated
070076 - Deceased Child, Female, 2 Year(s)	070079 - Grandparent, Female, 73 Year(s)	DOA / Fatality	Substantiated
070076 - Deceased Child, Female, 2 Year(s)	070079 - Grandparent, Female, 73 Year(s)	Inadequate Guardianship	Substantiated

070076 - Deceased Child, Female, 2 Year(s)	070079 - Grandparent, Female, 73 Year(s)	Lack of Supervision	Substantiated
070077 - Sibling, Female, 4 Year(s)	070078 - Mother, Female, 42 Year(s)	DOA / Fatality	Substantiated
070077 - Sibling, Female, 4 Year(s)	070078 - Mother, Female, 42 Year(s)	Inadequate Guardianship	Substantiated
070077 - Sibling, Female, 4 Year(s)	070078 - Mother, Female, 42 Year(s)	Lack of Supervision	Substantiated
070077 - Sibling, Female, 4 Year(s)	070079 - Grandparent, Female, 73 Year(s)	DOA / Fatality	Substantiated
070077 - Sibling, Female, 4 Year(s)	070079 - Grandparent, Female, 73 Year(s)	Inadequate Guardianship	Substantiated
070077 - Sibling, Female, 4 Year(s)	070079 - Grandparent, Female, 73 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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

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

Legal Activity Related to the Fatality

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

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
Bereavement services were offered on behalf of the parents; however, it was unknown if services were utilized. Funeral assistance was offered and was declined as the family had received financial assistance from the community.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes

Explain:
Bereavement services were offered to the family; however, it was unknown if services were utilized.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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 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