Child Fatality Report

Report Identification Number: SV-25-009

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

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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: 3 year(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 02/27/2025
Initial Date OCFS Notified: 02/27/2025

Presenting Information

An SCR reports was received on 2/27/25, which stated while in the care of the grandfather, the 3-year-old subject child wandered out of the home while the grandfather was in the bathroom. When the grandfather came out of the bathroom, he searched for the child inside and outside the home but could not find him. The grandfather then flagged down a police officer and notified him that the child was missing. Around 2:50pm, the child's body was found in a river near the home by a police officer. Emergency medical services arrived on scene and pronounced the child deceased at 2:57pm.

Executive Summary

This report concerns the death of a 3-year-old male child. On 2/27/25, Westchester County Department of Social Services (WCDSS) received an SCR report regarding the drowning which resulted in the subject child's death. At the time of the child's death, he resided with his mother, maternal grandfather, maternal aunt, maternal uncle, and cousins, ages 16 and 10.

During the investigation, multiple contacts were made with the family. It was learned that the subject mother left the child in the care of the maternal grandfather while she went to a nearby city for the day. The maternal grandfather reported that the child wandered away from the home while the grandfather was using the bathroom. He looked for the child inside and outside the home and then called the maternal uncle when he still could not locate the child. The uncle returned to the home and looked for the child before flagging down a police officer who was driving by. The police located the child in a nearby body of water, where the child was pronounced deceased at 2:57 pm.

The medical examiner was notified and performed an autopsy of the subject child. His cause of death was listed as drowning. Law enforcement investigated the incident but declined to press criminal charges.

Due to a fair preponderance of evidence, the allegations of DOA/Fatality, IG and LS against the subject grandfather were substantiated. The grandfather admitted to leaving the child unattended while he used the bathroom, and as a result the child left the home, and drowned.

Due to a fair preponderance of evidence, the allegations of IG and LS against the subject mother were substantiated. The grandfather did not know what to do in the case of an emergency, and the mother left the 3-year-old subject child in his care.

Due to a fair preponderance of evidence, the allegation of IG against the maternal uncle was substantiated. There was a significant delay in seeking additional assistance between when the uncle became aware the child went missing and when law enforcement was flagged down.

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:
The decision to close the case was appropriate. The other children in the home were deemed safe throughout the investigation.

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: 02/27/2025 **Time of Death:** 02:57 PM

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

County where fatality incident occurred: Westchester

Was 911 or local emergency number called? No

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

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	Aunt/Uncle	Alleged Perpetrator	Male	53 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	44 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	85 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Other Child - cousin	No Role	Female	16 Year(s)
Deceased Child's Household	Other Child - cousin	No Role	Female	10 Year(s)

LDSS Response

On 2/27/25, an SCR report was received regarding the death of a 3-year-old male subject child. WCDSS initiated their investigation within 24 hours, spoke with the source of the report, notified the district attorney, coordinated with law enforcement and completed a CPS history review of the family.

WCDSS completed a thorough home visit. The subject mother reported that she left the subject child in the care of the maternal grandfather the morning of 2/27/25, while she went shopping in a neighboring city with the maternal aunt. She stated the maternal uncle who resided in the home, was attending an unrelated court hearing at the time and the cousins who also resided in the home, were at school during the incident. She stated the grandfather had watched the subject child many times previously, while she was at work. She stated they would typically watch television together while she was gone, and the grandfather would prepare him meals as needed. She denied the child had ever wandered off or went outside by himself before.

The maternal uncle reported that at approximately 1:00pm he received a phone call from the grandfather stating he could not locate the child. The grandfather informed him that he went to the bathroom for a few minutes and when he came out of the bathroom, the child was gone. The uncle stated he returned home and looked for the child but could not locate him, so he flagged down a police car for assistance.

WCDSS requested to interview the maternal grandfather several times throughout the investigation but was repeatedly denied by the family. The family stated the grandfather was unaware that the child was deceased. They reportedly told him

the child was hospitalized and then went to reside with his biological father. They stated the grandfather had a stroke when his wife died a few months prior and had suffered from high blood pressure and depression since. They felt that telling him that the subject child had died would have a negative impact on his mental and physical health due to his advanced age.

Law enforcement reviewed cameras from neighboring homes to confirm the timeline of events. The subject child was observed leaving the home at 12:10pm. The grandfather was observed outside looking for the child at 12:12pm. The uncle returned to the home and began looking for the child at 1:30pm. At 2:28pm, the uncle flagged down a passing police car to request assistance. Law enforcement located the child in a nearby body of water and he was pronounced deceased by EMS at 2:57pm.

WCDSS made appropriate collateral contacts and reviewed medical, police and school records for the family. The other children who resided in the home were deemed safe throughout the investigation. WCDSS offered the family grief counseling, which they were receiving at the close of the investigation.

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

Comments: The fatality was referred to the Westchester County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
071008 - Deceased Child, Male, 3 Year(s)	071009 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
071008 - Deceased Child, Male, 3 Year(s)	071009 - Mother, Female, 27 Year(s)	Lack of Supervision	Substantiated
071008 - Deceased Child, Male, 3 Year(s)	071010 - Grandparent, Male, 85 Year(s)	DOA / Fatality	Substantiated
071008 - Deceased Child, Male, 3 Year(s)	071010 - Grandparent, Male, 85 Year(s)	Inadequate Guardianship	Substantiated
071008 - Deceased Child, Male, 3 Year(s)	071010 - Grandparent, Male, 85 Year(s)	Lack of Supervision	Substantiated
071008 - Deceased Child, Male, 3 Year(s)	071011 - Aunt/Uncle, Male, 53 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

The family refused to allow the Department to interview the maternal grandfather due to his advanced age and his physical and mental health concerns.

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	☒	☐	☐	☐

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 as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The surviving cousins, who resided with the subject child, were engaged in grief counseling at the close of the investigation.

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:
The family received grief counseling services.

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

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