Child Fatality Report

Report Identification Number: SV-17-033

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

Issue Date: Nov 17, 2017

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: Rockland
Gender: Male
Date of Death: 08/06/2017
Initial Date OCFS Notified: 08/08/2017

Presenting Information

The SCR received a report on 8/7/17 regarding the death of the SC. The narrative stated that on 8/6/17, the SM failed to provide adequate supervision to the one-year-old SC for an unknown length of time. As a result, the SC was standing in the street when a taxi cab backed out of a driveway and struck the child, which resulted in the his death. The role of the BF was unknown.

Executive Summary

On 8/7/17, Rockland County Department of Social Services (RCDSS) received an SCR report regarding the death of the 16-month-old SC. The report alleged that on 8/6/17 the SM was not adequately supervising the SC and he was hit and killed by a taxi. The SC was an otherwise healthy child and not taking any medications. The SC had no SS.

The ME performed a post mortem examination of the SC, but did not do an autopsy. An autopsy was against the religious beliefs of the SM and BF. Based on the ME's exam, the manner of death was ruled an accident. The cause of death was multiple blunt impact injuries of the head, torso and extremities due to pedestrian being struck by a vehicle (taxi).

Through interviews of the BF, SM, EMS, ER staff, witnesses, the taxi driver and the SC's pediatrician, RCDSS learned the SC was run over by a taxi on 8/6/17 and died as a result of his injuries. The BF was inside the home laying down while the SC was playing outside. The SM was responsible for caring for the SC in the time he was hit by the car. The SM allowed the SC to play outside with the neighbor's children on the date of the fatal incident. The SC and the CHN that lived in a neighboring apartment frequently played outside together and at each other's homes. The SM and the mother of the CHN both acknowledged there was an unspoken agreement to look after all the CHN. On 8/6/17 the CHN and SC were playing together. The SM saw the CHN outside and in the doorway of the CHN's home. The SM said she was standing in the doorway of her home when she saw the taxi back up over the SC. The SM yelled to alert the taxi to stop, but he did not stop the car. The SC was sitting at the end of the driveway and the taxi cab driver did not see him there. The taxi cab driver stopped the car after his front tire was stuck on something. The driver emerged from the car and found he had backed his car up over the SC. The SM alerted the SF to what had happened and called 911. The BF and SM ran to the road to help the SC until EMS arrived, but the SC was already deceased.

RCDSS jointly investigated the fatality with LE. LE advised RCDSS that criminal charges were pending against the SM for Endangering the Welfare of a Child. RCDSS appropriately substantiated the allegations of IG, DOA/Fatality and LS against the SM regarding the SC. RCDSS documented various interviews with witnesses to the fatal incident and there was some credible evidence that the SM failed to appropriately supervise the SC on 8/6/17. As a result, the SC was alone in the street and struck by a taxi. The death of the SC was caused by the injuries he sustained.

RCDSS did a thorough investigation of the events leading up to the fatality including speaking to numerous collateral contacts. RCDSS was very respectful of the SM and BF's religious observances in terms of allowing them time to formally grieve the death of the SC. The SM and BF declined grief services offered by RCDSS. The parents had the support of their religious community and had these services already.

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?** 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 casework was commensurate with the case circumstances. There was sufficient information gathered to make a determination and close the case.

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: 08/06/2017 **Time of Death:** 05:20 PM

Time of fatal incident, if different than time of death: 04:00 PM

County where fatality incident occurred: Rockland
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? No - but needed

At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☒ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☐ Asleep
- ☐ Impaired by illness
- ☐ 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	27 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)

LDSS Response

After receiving an SCR report on 8/7/17 regarding the death of the SC, RCDSS contacted the source, LE, first responders, neighbors, witnesses, ER staff, the SC's doctor and the ME. LE interviewed the taxi driver, SM and BF regarding the fatality. LE reported the SC was sitting at the end of the driveway with his back facing the rear of the taxi that was there. The taxi driver did not see the SC and backed the car up hitting the SC.

RCDSS contacted the religious community liaison and scheduled a visit with the BF. RCDSS learned the BF and the SM were home with the SC when the fatal incident occurred. The BF was in and out of the home on the day of the fatality. The BF went to lay down in bed at about 4:00PM. Soon after, the SM came into the bedroom yelling that the SC had been hit, while she simultaneously called 911. The BF and the SM both went outside. The BF said the SC was on the ground underneath the taxi and he did not recall much after that.

The SM said she woke at 6:00AM on the day of the fatality and spent the day with the SC. The SM said earlier in the day she took the SC outside. The SC ran into the road and sat down. The SM collected the SC from the road and brought him back inside. The SM told the SC he cannot run into the road. The SC played inside for a bit, but then wanted to go back outside. The SM took him outside again and the SC saw the two neighboring CHN were also outside and he went over to the CHN. The SM then saw the SC standing in the doorway of the neighbor’s home. The SM reported it is not unusual for the SC and the neighboring CHN to run in and out of each other's homes, and there is an unspoken agreement with her neighbor that they watch out for the CHN. The SM said she was standing on the grass outside watching the children play. The SM reported the next thing she remembered was seeing a taxi in the driveway backing up toward the SC and yelling for it to stop. The SM did not remember the taxi arriving in the driveway. The SM ran to the SC and tried to lift the taxi up off him. The SM then ran into the home to call EMS. The SM tried to perform CPR on the SC but knew he was already gone. The SM said she was outside in the doorway of the home when the events took place. The SM said the SC is fast and she tried to stop it by yelling to the taxi.

LE interviewed the 5yo CH that was playing with the SC at the time of the accident. The child showed LE where the SC was sitting on the driveway when the taxi hit him. The CH denied seeing the SM outside. RCDSS interviewed the 5yo's mother and she confirmed it was common for her children and the SC run back and forth to each other's houses. She explained the SC was inside her home minutes before the taxi hit him, and she told him it was time to go home. The

neighbor recalled her 5yo CH told her the SC was hit by a car. She reported her CH and the SC were the only CHN outside because her two sons were inside the home with her. When she went outside the SM was standing by the taxi yelling and trying to lift the car off the SC. She was clear the SM did not tell her she was stepping inside the house that day.

RCDSS interviewed the taxi driver and his passenger. The taxi driver recalled pulling partially into the driveway and seeing a male and female CH sitting in the doorway of the home on top of the driveway, but no adults around the home. The passenger got into the back of the car and the driver then began to back up out of the driveway. The driver reported that he then felt like something was stuck under his tire and he stopped the car. The driver reported when he got out of his car the SM was already standing there. The driver said that the two CHN he initially saw when he pulled up were still there when he realized he had hit the SC with the taxi. The passenger confirmed the driver's report of events that took place.

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: Hospital physician

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?No

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041781 - Deceased Child, Male, 1 Year(s)	041674 - Mother, Female, 23 Year(s)	Lack of Supervision	Substantiated
041781 - Deceased Child, Male, 1 Year(s)	041674 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
041781 - Deceased Child, Male, 1 Year(s)	041674 - Mother, Female, 23 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?	☒	☐	☐	☐
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 Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but 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 parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
RCDSS offered grief services to the parents, but the SM and BF declined the services. The SM and BF received grief services from their religious community.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? 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? N/A
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 is no known CPS History for either parent prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS History outside of New York State.

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

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