Child Fatality Report

Report Identification Number: SV-17-034

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

Issue Date: Dec 13, 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: 3 year(s)
Jurisdiction: Nassau
Gender: Male
Date of Death: 07/27/2017
Initial Date OCFS Notified: 08/14/2017

Presenting Information

On 8/11/17 an SCR report was received alleging the SC was hit by a car and subsequently died. The SC lived with the SM and was being supervised by an 18yo friend (OA1) of the SM's the night of the fatal incident. The report alleged the SM had a history of drug and alcohol misuse, and failed to appropriately supervise the SC. On 7/27/17 the SM went to work and left the SC with the OA1. The OA1 then dropped the SC off at a park with a 10yo child and failed to make an appropriate plan for his care. While at the park the SC ran into the parking lot of the park and was struck by a car. The SC died as a result of his injuries.

Executive Summary

This report concerns the death of a 3-year-old male child. On 8/11/17 Nassau County Department of Social Services (NCDSS) received an SCR report regarding the fatal incident and subsequent death of the SC that occurred on 7/27/17. The report alleged the SM was misusing drugs and alcohol and failing to consistently provide adequate supervision to the SC and SS. It further alleged the SM left the SC with an 18yo family friend (OA1) and he was not properly supervised when he was hit by a car and died as a result of his injuries. There were allegations of maltreatment against both the SM and OA1.

During the investigation, NCDSS found the SM was working at the time of the fatal incident and the SC was in the care of another family friend (OA2), not OA1. The SM had left the SC with OA1 when she went to work, but later agreed that OA1 would take the SC to OA2 to care for until the SM was finished working. OA2 took the SC and her own CH (age 10) to an area park. There were 2 parks at adjoining housing complexes, with a parking lot in between. The SC and OA2's CH were playing and the OA2 had gone to her car for a minute. In that time OA2's CH left the SC in the park playing with other CHN and she walked to see a cousin that pulled into the parking lot. The SC followed the CH and was hit by a car driving through the parking lot.

The ME performed an autopsy on the SC after a car accident where the SC was struck by a moving vehicle. The ME determined the cause of death to be blunt force trauma to the head, resulting in multiple skull fractures and consistent with the circumstances reported. The manner of death was determined an accident.

LE was involved and did an investigation. LE arrested the driver of the car for unlicensed operation of a motor vehicle (driving with a suspended license) at the scene of the accident. The investigation remained open awaiting toxicology reports of the driver. LE did not pursue criminal charges against the SM and OA2, as they determined that the SM had made an appropriate plan for the SC while she was at work, and LE further determined OA2 was providing adequate supervision.

NCDSS made several visits to both the SM's and OA2's homes. The SS and the OA2's four children were seen several times and interviewed. NCDSS attempted to reach OA1, but were unable to locate her despite diligent efforts. NCDSS unsubstantiated the allegations of IG, LS and DOA/Fatality against the SM and OA1 and PD/AM against the SM. NCDSS found the SM and OA1 were not present during the fatal incident and both adults had made an appropriate plan for his care. NCDSS added and substantiated the allegation of IG against OA2. NCDSS determined although she was in the immediate vicinity of the SC when the accident occurred, she was not providing age appropriate supervision. NCDSS did not interview the driver of the vehicle that hit the SC but had gathered sufficient information to make a determination.

NCDSS offered counseling and bereavement services to the SM, OA2, SS and the OA2's four children. All parties declined these services as they were seeking services on their own as necessary.

As a result this review, OCFS found a practice issue. NCDSS will submit a Program Improvement Plan (PIP) to the Regional Office within 30 days of receipt of this report. This PIP will identify what action(s) NCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, NCDSS will review the plan(s) and revise as needed to further address on-going concerns."

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 case closure was appropriate.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP was not accurate because OA2 was not identified as a secondary caretaker. OA2 was the subject of the maltreatment of the SC and therefore should have been included in the risk assessment.
Legal Reference:	18 NYCRR 432.2(d)
Action:	NCDSS will properly identify and include caretakers when completing the Risk Assessment Profile in a CPS Investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/27/2017 **Time of Death:** 09:40 PM

Time of fatal incident, if different than time of death: 09:00 PM

County where fatality incident occurred: Nassau
Was 911 or local emergency number called? Yes
Time of Call: 09:04 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: walking through parking lot

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	3 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Other Household 1	Other Adult - OA2	Alleged Perpetrator	Female	33 Year(s)
Other Household 1	Other Child - OA2's CH	No Role	Female	10 Year(s)
Other Household 1	Other Child - OA2's CH	No Role	Male	16 Year(s)
Other Household 1	Other Child - OA2's CH	No Role	Female	16 Year(s)
Other Household 1	Other Child - OA2's CH	No Role	Female	14 Year(s)
Other Household 2	Other Adult - BF to SS	No Role	Male	28 Year(s)
Other Household 3	Other Adult - OA1	Alleged Perpetrator	Female	18 Year(s)

Other Household 4	Other Adult - BF of OA2's CH	No Role	Male	46 Year(s)
Other Household 5	Other Adult - BF to OA2's 3 CHN	No Role	Male	45 Year(s)

LDSS Response

On 8/11/17 NCDSS received an SCR report regarding the death of the 3yo SC that occurred on 7/27/17. NCDSS contacted LE, the DA and the ME. NCDSS learned through the pediatrician that the SC was an otherwise healthy child.

NCDSS interviewed the SM and learned the fatal incident took place on 7/27/17. The SM went to work for her 2:00-10:00pm shift and left OA1 in her home to babysit the SC. The 9yo SS was at his PA's home when the SM went to work. The SM reported at about 5:45PM OA1 took the SC to a park to meet up with OA2. The SM was aware that OA2 would be babysitting the SC until she was done with work at 10:00PM, and therefore OA2 was responsible for the SC's care. At about 6:30PM OA2 took SC and her own CH (age 10) to the SM's workplace and the SM gave the CHN food. The SM then returned to work and OA2 and the CHN left. The SM planned to call OA2 when she was done working so they could meet and SM could take the SC home. At 9:00PM the SM received a phone call from OA2. OA2 reported the SC had been hit by a vehicle. The SM immediately left work and went to the parking lot in between 2 parks where the SC was located. The SM reported seeing the SC lying on the ground when she arrived. The SM and EMS arrived at the same time and the SM accompanied the SC in the ambulance to the ER. The SM reported at the ER OA2 informed her that she had gone to her car for a brief time and the SC and her 10yo CH were playing in the park with other neighborhood CHN. The SC then followed the 10yo CH into the parking lot and ran out between 2 parked cars and was hit. The SM said that shortly after arriving at the hospital, the Dr. came out and informed her the SC had passed away from the injuries caused by the car hitting him. The SM denied any drug or alcohol use. The SM stated that the BF of the SC was deceased and that was confirmed by NCDSS.

While at the home of the SM, NCDSS interviewed the 9yo SS. The SS reported missing the SC, but had no knowledge of the events that occurred. The SS was clear he had spent the night at his PA's home. The SS regularly visits the PA's home. NCDSS observed the SS to be healthy and comfortable in the SM's home. The home had appropriate food and sleep provisions.

NCDSS interviewed OA2, in addition to her four CHN (ages 16,16,14 and 10). The only CH that witnessed the fatal events was the 10yo CH. The 10yo told NCDSS she and the SC were playing in the park with other CHN and OA2 was there with them, on the sidewalk. The 10yo walked from the park to the adjoining parking lot to visit a cousin that pulled in. The SC was still in the park playing when she walked away. The 10yo reported she then heard what sounded like a bottle breaking and turned to see the SC lying on the ground. The CH yelled for her mother, OA2 and she ran over. The two 16yo CHN and the 14yo were aware of the accident, but were not there the night it occurred. NCDSS assessed all the CHN and the home and deemed they were safe in the care of OA2.

OA2 told NCDSS the same version of events the SM had reported. OA2 reported that she was on the sidewalk in front of the mailboxes near the entrance of the apartment complex when the SC was struck by the car. The OA2 reports she could see the 10yo CH and SC. The OA2 heard the 10yo scream and she ran to her. She saw the SC lying on the ground of the parking lot, and the driver of the car was walking through the parking lot. The driver apologized and said he did not see the SC and did not know he hit him. OA2 reported the music in the driver's car was very loud. There was no suspicion OA2 used alcohol or drugs.

NCDSS also spoke with the PA of the SS and the BF of the SS. They both expressed they had no concerns for the SM's care of the SC or SS. NCDSS also notified the BF's of OA2's CHN about the report and attempted to locate and speak with them. NCDSS searched for OA1 but were unable to locate her. SM said she had left the country after the death of the SC and she had no contact with her.

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 reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
041873 - Deceased Child, Male, 3 Yrs	041876 - Other Adult - OA2, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
041873 - Deceased Child, Male, 3 Yrs	041882 - Other Adult - OA1, Female, 18 Year(s)	Lack of Supervision	Unsubstantiated
041873 - Deceased Child, Male, 3 Yrs	041875 - Mother, Female, 26 Year(s)	Lack of Supervision	Unsubstantiated
041873 - Deceased Child, Male, 3 Yrs	041882 - Other Adult - OA1, Female, 18 Year(s)	DOA / Fatality	Unsubstantiated
041873 - Deceased Child, Male, 3 Yrs	041875 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
041873 - Deceased Child, Male, 3 Yrs	041875 - Mother, Female, 26 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
041873 - Deceased Child, Male, 3 Yrs	041882 - Other Adult - OA1, Female, 18 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐

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:
OA1, and two of the BF's could not be located during the investigation, but diligent efforts were made to interview them. The driver of the car that struck the SC was not interviewed by NCDSS nor were attempts to do so documented.

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 safety 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 OA2 was identified as the second caretaker in the Risk Assessment Profile, so questions were not answered appropriately to reflect the totality of risk.

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	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	☐	☐	☐	☐	☐	☒	☐

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? 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 an SCR report opened 7/29/11 and closed on 10/5/11 with an allegation of IG Unsub against OA2 regarding an unrelated CH.

Known CPS History Outside of NYS

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

Preventive Services History

OA2 requested preventive services in an effort to begin PINS Diversion Services for her teenage daughter. The case was opened on 5/17/17. The services provided to OA2 and her CH were PINS diversion groups, MH counseling and education intervention services. The CH continued to miss school during the open services case. The OA2 did not follow through on MH and substance abuse referrals for the CH. The OA2 requested the preventive services case be closed because the CH moved out of state with family members. The case concluded on 6/28/17.

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

Additional Local District Comments

Nassau does not agree with listing OA2 as a secondary caretaker on the RAP. The RAP is a tool utilized to calculate the future risk of children being abused or neglected within the next 2 years. With that being stated, OA2 has not cared for the 9-year-old surviving child in the past or will in the future. Therefore OA2 does not pose any risk to the surviving child.

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