Child Fatality Report

Report Identification Number: SV-20-023

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

Issue Date: Oct 19, 2020

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: 7 year(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 05/31/2020
Initial Date OCFS Notified: 05/31/2020

Presenting Information

An SCR report was received on 6/1/20 which alleged on 5/31/20, at approximately 10:15PM, the 7-year-old subject child wandered out of his home unsupervised while in the care of his mother and father. While unsupervised, the child left the backyard and walked onto the nearby highway, where he was struck by a vehicle in a hit and run accident. The child sustained blunt force trauma and bleeding from both airways. A passerby found the child's body on the side of the highway, and police responded to the scene. The child was transported to the hospital and pronounced dead.

Executive Summary

This fatality report concerns the death of a seven-year-old male subject child that occurred on 5/31/20. A report was made to the SCR on 6/1/20 with allegations of Inadequate Guardianship, Lack of Supervision, Fractures, Internal Injuries and DOA/Fatality against the child's mother and father. Suffolk County Department of Social Services (SCDSS) received the report and investigated the child's death. An autopsy was completed; however, the final report was not yet available at the time of this writing. SCDSS spoke with the medical examiner, who stated the child's official cause of death was Atlanto-occipital dislocation.

At the time of the child's death, he resided with his mother, father, two adult siblings, and five surviving siblings, ages 17, 16, 14, 13 and 9 years old. The father was out of the country on the date of the incident and was unable to return until several days after the child died. The investigation revealed the child had significant developmental delays and required heightened supervision, as he had a history of absconding from the home. On the night of 5/31/20, an adult sibling and the 16-year-old sibling were asked by the mother to keep an eye on the child as she was tired and falling asleep on the couch. At the time, the child was sitting beside the mother on the couch, watching television, and the siblings responsible for his supervision were cleaning up in the nearby kitchen. The other siblings were in their bedrooms, either sleeping or playing with their electronics. At approximately 10:00PM, the adult sibling noticed the child was no longer in the living room. She and the 16-year-old sibling woke the mother, and all began searching the home to no avail. The child had a recent history of leaving the home and most recently was found walking down the nearby freeway, so the adult sibling and 16-year-old began to search outside and through the woods on foot. Shortly thereafter, as the siblings emerged close to the freeway, they were stopped by a police officer and informed a child was the victim of a hit and run. The officer brought the siblings to where the child lay; emergency services had already responded. The child was transported via ambulance to the hospital where he was pronounced deceased at 10:48PM. The driver of the vehicle that struck the child had still not been identified at the time of this writing.

From the time the investigation began to the time of its closure, SCDSS interviewed family members and numerous pertinent collateral sources. Law enforcement found no criminality on behalf of the mother, father or adult siblings. SCDSS provided the family with appropriate service referrals in response to the death of the child, including voluntary prevention services to address ongoing needs, which they declined. Due to the child's developmental status and history of being found unsupervised outside of the home, SCDSS substantiated allegations against the mother and closed the case.

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

Explain:
SCDSS gathered sufficient information to appropriately determine the allegations and assess the safety of the SS.

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 record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the 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: 05/31/2020 **Time of Death:** 10:48 PM

Time of fatal incident, if different than time of death: 10:00 PM

County where fatality incident occurred: Suffolk

Was 911 or local emergency number called? Yes

Time of Call: 10:01 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

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was: Not impaired.

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	Adult Sibling	No Role	Male	20 Year(s)
Deceased Child's Household	Adult Sibling	No Role	Female	18 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	7 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	38 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	No Role	Female	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	17 Year(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)

LDSS Response

On 6/1/20, SCDSS received the SCR report regarding the death of SC, which occurred on 5/31/20. SCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. SCDSS learned there were 5 SS and worked promptly to assess their safety.

On 6/1/20, SCDSS completed a visit to the family's home. SCDSS was informed by the 18yo SS that SM, the 20yo SS, and the 16yo SS were still at the hospital, and SF was still overseas trying to get home. The 18yo explained she and other family members were caring for the CHN in the meantime. The 18yo explained that on the night of 5/31/20, at approximately 9:15PM, she and the 16yo were in the kitchen cleaning up while SM and SC were in the living room on the couch. The 18yo explained SM informed her and the 16yo to keep an eye on SC, as she was tired and may fall asleep on the couch. The 18yo stated she checked on SC every few minutes and could also hear SC making noises as he watched TV. She said at some point, she could no longer hear SC, and when she went to check on him, he was no longer in the living room. The 18yo stated she and the 16yo woke up SM, and they began looking in the house where SC usually liked to hide. The 18yo said he was nowhere so they remembered he recently wandered out of the house toward the highway, so they started looking for him on foot outdoors. The 18yo explained when she and the 16yo approached the roadway through the woods, LE stopped them and brought them to SC's body, which was lying on the side of the freeway. The 18yo said SC had been hit by a car and the person driving did not stop. The 18yo reported the other SS were in their rooms sleeping

or on their electronics when all of this occurred.

On this same date, SCDSS interviewed the 9 and 13yo SS. Both reported they were in their rooms until they heard yelling that SC was missing. They reported LE was at their house to talk with SM and said everyone was sad and crying. Both denied that SC had run off alone before other than the back yard, and both denied any safety concerns in the home. SCDSS attempted to interview the 14 and 17yo SS; however, they were too upset to speak with caseworkers at that time. The home environment was observed, and it was noted an open bedroom window in very close proximity to the back deck and could have been how SC absconded from the home.

On 6/4/20, SCDSS interviewed the 14, 16, 17 and 20yo SS. All their stories corroborated the events reported by others thus far. The 17yo explained SC was "very fast," but if ever he did leave the house, a family member was usually right behind him. The 17yo also stated there were extra locks on the doors and maybe someone left one open by accident the night SC died. None of the SS expressed any safety concerns. On this same date, SF and SM were spoken with; however, SM was still too upset to talk about what happened. SF explained he was out of the country when the incident occurred and was notified of what happened by his daughters. He explained all family members tried to keep an extra eye on SC as he was quiet and could be very fast if he wanted to get out of the home. SF explained he installed extra locks on the doors last year to help keep SC safe. He denied any concerns regarding SM's ability to care for the CHN and felt what occurred was a tragic accident.

Throughout the investigation, SCDSS spoke with numerous collateral sources and the safety of the SS was assessed on several occasions. Neighbors reported concerns SC was often left unsupervised outside, which SCDSS addressed with the parents. There were no criminal charges brought against any family members regarding SC's death. Due to SC's significant developmental delays and recent history of absconding from the home, SCDSS substantiated the allegations of LS and IG against SM. Appropriate services were offered to the family but declined. The case was indicated and closed.

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
Comments: This fatality investigation was conducted by the Suffolk County multidisciplinary team.

Was the fatality reviewed by 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
055195 - Deceased Child, Male, 7 Yrs	055197 - Father, Male, 38 Year(s)	DOA / Fatality	Unsubstantiated
055195 - Deceased Child, Male, 7 Yrs	055197 - Father, Male, 38 Year(s)	Fractures	Unsubstantiated
055195 - Deceased Child, Male, 7 Yrs	055197 - Father, Male, 38 Year(s)	Inadequate Guardianship	Unsubstantiated

055195 - Deceased Child, Male, 7 Yrs	055197 - Father, Male, 38 Year(s)	Internal Injuries	Unsubstantiated
055195 - Deceased Child, Male, 7 Yrs	055197 - Father, Male, 38 Year(s)	Lack of Supervision	Unsubstantiated
055195 - Deceased Child, Male, 7 Yrs	055196 - Mother, Female, 40 Year(s)	DOA / Fatality	Unsubstantiated
055195 - Deceased Child, Male, 7 Yrs	055196 - Mother, Female, 40 Year(s)	Fractures	Unsubstantiated
055195 - Deceased Child, Male, 7 Yrs	055196 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Substantiated
055195 - Deceased Child, Male, 7 Yrs	055196 - Mother, Female, 40 Year(s)	Internal Injuries	Unsubstantiated
055195 - Deceased Child, Male, 7 Yrs	055196 - Mother, Female, 40 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:

SCDSS interviewed the family and appropriate collateral sources. Progress notes and other documentation were completed and entered timely.

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	☒	☐	☐	☐
Explain: SCDSS offered the family appropriate services in response to the SC's death.				

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?	☐	☒	☐	☐
Explain as necessary: The SS did not need to be removed.				

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	☐	☒	☐	☐	☐	☐	☐

Other, specify: Preventive Services

Additional information, if necessary:
SCDSS provided the parents bereavement counseling referrals. SCDSS also provided the parents with information on assistance with funeral costs. Prevention services were discussed; however, the family declined.

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? Yes
Explain:
SCDSS provided the family service referrals; however, they declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
SCDSS provided the family service referrals; however, they declined.

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)
04/23/2019	Deceased Child, Male, 6 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Male, 6 Years	Mother, Female, 39 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
This SCR report was received with concerns SC, who was non-verbal and required a higher level of supervision, walked out of the back yard of the home through a hole in the fence, and wandered into a neighbor's yard to play on a trampoline. SM was unaware SC was missing for 5 to 10 minutes. The neighbor contacted police, and SC was unharmed.

Report Determination: Unfounded | **Date of Determination:** 06/27/2019

Basis for Determination:
SCDSS completed a thorough investigation of the allegations and found SM had been outside with SC when he wandered away; however, her back had been turned as she was raking leaves. SM and other family members acted appropriately when they noticed SC was no longer in the yard and found him jumping on the neighbor's trampoline. The hole in the fence was repaired by the close of the investigation, and the CHN were deemed safe.

OCFS Review Results:
This investigation met all statutory requirements.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/22/2018	Deceased Child, Male, 5 Years	Mother, Female, 38 Years	Inadequate Food / Clothing / Shelter	Far-Closed	No
	Deceased Child, Male, 5 Years	Mother, Female, 38 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 5 Years	Father, Male, 36 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Deceased Child, Male, 5 Years	Father, Male, 36 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
This SCR report was received with concerns SM and SF were not appropriately caring for SC, who had special needs. SC was often dirty and exhibited body odor. There were further concerns he was not being fed at home.

OCFS Review Results:
This investigation was appropriately tracked to FAR. SCDSS completed interviews with family members and collateral sources. The parents denied the allegations, but reported it was difficult at times to get SC to bathe due to his developmental delays and a fear of water. The home was observed with plenty of food and appropriate provisions. SCDSS observed SC to be clean, wearing neat clothing. SCDSS discussed services and community supports with the parents; however, the declined referrals. There were no safety issues noted, and the FAR case was closed.

This investigation met all statutory requirements.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

There is 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