Child Fatality Report

Report Identification Number: SV-16-036

Prepared by: Spring Valley Regional Office

Issue Date: Mar 21, 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	

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
CPR-Cardio-pulmonary Resuscitation		
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-Others	
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	

Case Information

Report Type: Child Deceased
Age: 1 year(s)
Jurisdiction: Sullivan
Gender: Male
Date of Death: 09/05/2016
Initial Date OCFS Notified: 09/05/2016

Presenting Information

This case was called in to the New York Statewide Central Register of Child Abuse and Maltreatment on 9/5/2016 listing allegations of DOA/Fatality, Inadequate Guardianship and Lack of Supervision on behalf of the 1-year-old subject child, regarding the mother. This report alleged that the mother was not supervising the subject child and as a result, the subject child ran across a parking lot and was struck on the forehead by a vehicle that was backing up. The subject child died as a result of the injuries sustained during this incident.

Executive Summary

The investigation revealed that on 9/5/2016, the mother and subject child went to the father's auto-garage where he is employed to wait for him to go to the playground. The garage was closed for the day, and the father was there cleaning up in preparation for routine garage inspections. A family friend was also at the garage, and had entered his van and began to back up to exit the parking lot. Video surveillance revealed the van went from around the back of the shop, into the parking lot in front of the building where the family was, and struck the subject child who was standing holding a ball. The parents were only a few feet away from the subject child when the incident occurred, and it took the parents only two seconds from where they were standing to reach the subject child. The mother picked up the subject child and got into the back of the van while holding him, and the uncle (unknown if maternal or paternal), who was also present at the garage, got in the driver's seat and left en route to the local hospital. The father attempted to also enter the van, however the uncle quickly drove away not giving the father enough time to enter the vehicle. The subject child arrived at the hospital at 1:47 PM, he was unresponsive, had suffered head trauma and was in cardiac arrest. He was pronounced dead the same day.

An autopsy was performed on the subject child on 9/6/2016. The Medical Examiner noted that the cause of death as blunt force trauma of the head and the manner of death as accidental, pedestrian struck and ran over by minivan. Local law enforcement officials investigated the case and estimated the vehicle to have been traveling at a rate of 3 miles per hour at the time of impact. The driver did not appear to be under the influence of any substances at the time of the incident and toxicology reports supported this. The driver was cited for not having a valid driver's license at the time of the incident, however it was determined that it was a tragic accident.

The surviving 3-year-old male sibling and 7-year-old maternal aunt who resided in the home were assessed to be safe and well throughout the investigation. Records indicated the children were up to date with immunizations and no concerns were noted by the pediatrician.

The allegations of DOA/Fatality, Inadequate Guardianship and Lack of Supervision listed on the report were determined to have been unsubstantiated regarding the mother on behalf of the subject child. The mother was an appropriate distance away from the subject child at the time of the incident, and responded appropriately. There was no reason to believe the subject child was in danger as the shop was closed on this particular day, and there was no activity in the parking lot. Appropriate service referrals were offered to the mother, father, and extended family members and these were accepted. At the time of case closure, the family was working with Special Assistance Trauma Unit (SATU) Services, and referrals were made for peer counselors and spiritual guidance. SCDSS also attempted to obtain aid in funeral expenses for the family, however there was no remaining balance owed to the

funeral home at the time the services were offered. Sullivan and Orange counties collaborated in the investigation and subsequent community services. The case was closed on 10/28/2016.

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?** No
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** No

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:
All completed assessments, and the decision to unfound and close the case were appropriate.

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 as unfounded was appropriate.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	While the 9/6/2016 note indicated a 24-hour safety assessment was completed and the sibling was seen and deemed safe, the corresponding assessment documentation was not completed in Connections.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	Within thirty days of the issuance of this report, Sullivan Division of Family Services will submit a corrective action plan to OCFS to address completion of 24 Hour Assessments.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/05/2016 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 01:30 PM

County where fatality incident occurred: ORANGE
Was 911 or local emergency number called? No
Did EMS to respond to the scene? No
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? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	7 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	No Role	Male	30 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	37 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	41 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	No Role	Male	3 Year(s)

LDSS Response

Sullivan County Division of Family Services (SCDFS) conducted an investigation into the allegations listed on the report and collaborated with Orange County in the investigation as the child was taken to a hospital in Orange. SCDFS made appropriate collateral contacts including the local law enforcement officials, hospital staff, the Medical Examiner, relatives, and community resources, and worked in conjunction with Orange County Department of Social Services (OCDSS). All subjects were interviewed and observed, and the allegations were discussed. Appropriate service referrals

were offered to the family.

There was a surviving 3-year-old male sibling and a 7-year-old maternal aunt residing in the home. There was no indication the surviving sibling or the 7-year-old maternal aunt were present during the incident. The maternal aunt was not seen until 11/10/2016, however there was no indication the 7-year-old was residing in the home prior to this date. SCDFS completed the 7-day and investigation determination safety assessments and the risk assessment profile (RAP) accordingly. Although the case notes indicate that a 24-hour safety assessment was being completed on 9/6/2016, no 24-hour safety assessment was entered. There was also no 30-day safety assessment entered. The case notes were contemporaneous.

Medical records received indicated the subject child was brought to the hospital at 1:47 PM by the mother, with head trauma and in cardiac arrest. The subject child passed away the same day, however no time of death was documented. Although contact with the hospital was made, no information regarding the condition of the subject child, or the actions taken by medical personnel was obtained.

Local law enforcement officials explained that this appeared to have been a tragic accident, and no arrests have been made. During their investigation, local law enforcement officials determined the vehicle to have been traveling at a rate of 3 miles per hour, and toxicology reports revealed the driver was not under the influence of any substances at the time of the incident. The driver was cited for not having a valid driver's license at the time of the incident, however no additional citations or charges were made. The family retained an attorney through the Mexican Consulate in New York City, and plans on filing a suit against the driver of the vehicle.

There was documentation of supervisory conferences noted in which the circumstances of the case were discussed and directives were provided. The case was closed on 10/28/2016 and the allegations on the report were determined to have been unsubstantiated regarding the mother on behalf of the subject child for DOA/Fatality, Inadequate Guardianship, and Lack of Supervision. In collaboration with Orange County, appropriate service referrals were provided to, and accepted by the family.

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
Comments: The fatality investigation was conducted by an MDT team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: Sullivan County does not have an OCFS approved Child Fatality Review Team (CFRT). Orange County Department of Social Services (OCDSS) also decided that although the subject child was taken to a hospital in Orange County where he was pronounced dead, Sullivan County was handling the case and as a result, no CFRT meeting took place in Orange County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
034950 - Deceased Child, Male, 1 Yrs	034951 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Unsubstantiated
034950 - Deceased Child, Male, 1 Yrs	034951 - Mother, Female, 20 Year(s)	Lack of Supervision	Unsubstantiated
034950 - Deceased Child, Male, 1 Yrs	034951 - Mother, Female, 20 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
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?	☒	☐	☐	☐
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	☒	☐	☐	☐

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 siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐
Explain as necessary: No removal of the children residing in the household was necessary.				

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 Unavaliable	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: Play Therapy

Additional information, if necessary:
Appropriate services were offered to and accepted by the family. Play therapy was discussed with the supervisor and caseworker, however it is not documented that the caseworker discussed this with the family.

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? No
Explain:
A 9/15/2016 supervisory note indicated a directive for the caseworker to discuss play therapy for the surviving sibling with the parents. There is no indication this was done. SATU services were involved with the family, however it is also not documented if the 7-year-old maternal aunt was participating in those services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The family was very receptive to services and began working with a SATU worker for counseling. Additionally, they

requested spiritual guidance and a peer counselor.

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

The mother was listed in a FAR case that was opened on 6/19/2012 and closed on 7/11/2012 as there were no safety concerns noted and no services needed. This case appears to surround the mothers mental health issues in which she began to receive inpatient treatment, however it was determined by medical staff the mother did not need the services. There was also a case dated 10/18/2012 called in to the SCR listing allegations of Inadequate Guardianship and Sexual Abuse on the mother's behalf as she had gotten pregnant by her then 18-year-old boyfriend.

The father has no history in the current system of record.

Known CPS History Outside of NYS

There is no known history outside of New York State.

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

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

Action:	It is best practice for CPS investigators to complete the 30-Day Fatality Report in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No