# NYS Office of Children and Family Services - Child Fatality Report

**Report Identification Number: NY-16-050** **Prepared by: New York City Regional Office**

**Issue Date: 12/16/2016**

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:** 3 year(s)
**Jurisdiction:** Bronx
**Gender:** Female
**Date of Death:** 05/16/2016
**Initial Date OCFS Notified:** 05/16/2016

### Presenting Information

According to the narrative of the SCR report, on 5/16/16, the mother was walking the 3-year-old child to daycare. The mother was pushing her 23-month-old child in a stroller, leaving the three-year-old to walk by herself. The mother was walking a few feet ahead of the three-year-old child when they were crossing a road, leaving the three-year-old child unattended. The report alleged that as a result of the mother's negligence, a car struck and killed the three-year-old child.

### Executive Summary

The fatality report concerns the death of a 3-year-old female child. The family had no prior history. The report listed the allegations of DOA/Fatality, LOS, and IG of the SC by the SM. The ME listed the cause of death as blunt impact trauma and the manner of death an accident. The SC died on 5/16/16. ACS documented there is a 1-year-old SS who resides with the parents.

ACS gathered information about the circumstances of the SC's death and SS from the ME, LE, SM, BF, attending doctors, day care providers, neighbors, and family supports.

According to the information obtained, the mother was walking with the SC on their way to school. The child complained of her hands feeling cold, so the mother told the child to put one hand in her pocket and to hold the stroller with the other. The mother said she waited for the SC to catch up before starting off again. The child did not hold on to the mother or the stroller. As the mother walked ahead into the intersection, a car traveling towards the family hit the 3-year old child. the mother said she avoided being hit by pushing the stroller out of the way, but she was not able to save the 3-year-old. The driver of the car involved in the accident called 911 and remained on the scene until the police arrived. The mother said she called the father who ran from home to the scene of the accident. An EMS ambulance transported the mother and children to the hospital where resuscitative efforts continued. The child succumbed to her injuries at 9:05 AM on 5/16/16.

On 5/20/16 ACS held a Child Safety Conference, where the SM, BF and family members were in attendance. ACS referred the family to PPRS, bereavement counseling, play therapy, early intervention screening, housing assistance, burial assistance, and parenting classes.

On 6/1/16 ACS contacted LE who notified ACS of video footage of the accident. ACS requested the footage but was unsuccessful in obtaining video because of ongoing investigation by the Assistant District Attorney.

On 6/13/16 ACS filed an application for PPRS services.

On 6/20/16, and 7/12/16 ACS conducted home visits to the case address. ACS observed SC’s death certificate and SS. ACS observed a crib for the SS. SM requested a toddler bed. ACS also documented discussing Safe Sleep and bed sharing information with the family.

On 7/14/16 ACS learned that All Children's House Child Parent Psychotherapy Preventive Program was assigned to work with the family.

ACS regularly met with the SS and caretakers to ensure implementation of services. ACS case record indicates that the Notice of Existence and Notice of Indication were provided to the parents. ACS documented case remains open for preventive services.

On 7/15/16 ACS substantiated the case for DOA/Fatality and Inadequate Guardianship of the child by the mother.

## 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:**
ACS documented case work contact through out the investigation, by monitoring the SS and family until PPRS services was implemented.

**Was the decision to close the case appropriate?** N/A

**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:**
ACS documented case open with preventive services.

### Required Actions Related to the Fatality

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

| | |
|---|---|
| **Issue:** | Adequacy of Progress Notes |
| **Summary:** | The Progress notes were not entered contemporaneously. There were large gaps between events and |

| | |
|---|---|
| | the entering of progress notes. |
| **Legal Reference:** | 18 NYCRR 428.5 |
| **Action:** | ACS must submit a corrective action plan within 45 days that identifies the action the agency has taken or will take to address the citations identified in the fatality report. ACS must meet with staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed. |

## Fatality-Related Information and Investigative Activities

### Incident Information

**Date of Death:** 05/16/2016 **Time of Death:** 09:05 AM

**Time of fatal incident, if different than time of death:** 08:25 AM

**County where fatality incident occurred:** BRONX
**Was 911 or local emergency number called?** Yes
**Time of Call:** 08:34 AM
**Did EMS to 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: Child was crossing the street.

**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:** Unknown if they were impaired.

**Total number of deaths at incident event:**
**Children ages 0-18:** 001

### Household Composition at time of Fatality

| Household | Relationship | Role | Gender | Age |
|---|---|---|---|---|
| Deceased Child's Household | Deceased Child | Alleged Victim | Female | 003 Year(s) |
| Deceased Child's Household | Father | No Role | Male | 31 Year(s) |
| Deceased Child's Household | Mother | Alleged Perpetrator | Female | 31 Year(s) |

| | | | | |
|---|---|---|---|---|
| Deceased Child's Household | Sibling | No Role | Female | 2 Year(s) |

**LDSS Response**

On 5/16/16 ACS documented contact with the hospital where the child had been taken. ACS learned the SC arrived at the hospital with signs of trauma. The SC's body arrived at the hospital and was transported to the hospital's morgue therefore the hospital had no medical records. The ACS Specialist documented the SM told SC to place one hand in her pocket and her other hand on the stroller because she was cold she was cold. The SS was in the stroller.

On 5/16/16 ACS attempted contacts with the SM, BF, and SS at the case address. ACS contacted the building superintendent who indicated he did not have any concerns with the level of care the SC had received. Other neighbors indicated the mother was attentive to her children.

On 5/17/16 ACS contacted the Investigative Consultant (IC). The IC informed the Specialist the driver of the vehicle remained at the scene of the accident and was not arrested.

On 5/17/16 while conducting the investigation regarding the death of the three year old child, ACS learned, a few years prior (June, 2012), the mother's 4-year-old brother had also been hit by a car and died as a result of the injuries he sustained. ACS staff interviewed the mother regarding the death of her brother and learned that the child had been with a group of family members. The mother, who was then pregnant with the SC, was along with other relatives watching the children as they were playing outside. The 4-year-old attempted to cross the street to go to his aunt's house when he was hit by the car. The documentation did not reflect if the child's parents were present.

On 5/18/16 ACS documented contact with the SC's Head Start provider. The provider reported the SC was always clean, and did not present with behavioral concerns. The provider also reported there were no suspicious marks/bruises on the SC. ACS also documented contact with the head start provider for the SS on 5/18/16, 6/14/16, and 7/12/16; the provider reported the SS was inquiring about the whereabouts of SC; therefore, a referral for MH services was made.

On 5/18/16 and 5/19/16 ACS documented face-to-face contact with the SM, and SM's family at the grandparents' home. CPS observed safety hazards such as missing smoke detector. ACS documented that the SS was residing with the grandparents. ACS provided the family with working smoke detectors on 5/19/16.

On 05/19/16 ACS documented a re-referral to the IC for the family members residing at the grandparents address. The IC's database checks yielded no results. ACS also documented a referral to Sauti Yetu's community based organization.

On 5/20/16 ACS held a Child Safety Conference, where the SM, BF and family members were in attendance. ACS documented a determination to refer the family to PPRS, bereavement counseling, play therapy, early intervention screening, housing assistance, burial assistance, and parenting classes.

On 5/20/16 ACS documented face to face contact with the parents at the case address. According to the documentation, the SM provided ACS with a brief timeline of events and reported that SC's hands were cold, so she directed SC to put one of her hands in her pocket and the other hand on the stroller. The SM reported the SC was slightly behind her when she heard the SC state "Mommy, a car is coming;" simultaneously, the car struck the SC. ACS documented the BF was not present during the accident. ACS noted the SS had no physical injuries .

On 7/15/16 ACS substantiated the allegations of DOA/Fatality and Inadequate Guardianship of the 3-year-old child by the

mother. ACS documented the mother failed to exercise a minimum degree of care and did not supervise the child as the child crossed the street. The mother's failure resulted in the child being hit by the car and ultimately the child died.

ACS continues to monitor the family through Preventive Services.

## 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)?**No
**Comments:** The fatality investigation was not conducted by an MDT; however. the investigation adhered to previously approved protocols for joint investigation.

**Was the fatality reviewed by an OCFS approved Child Fatality Review Team?**No
**Comments:** There is no OCFS approved Child Fatality Review Team in the NYC region.

## SCR Fatality Report Summary

| Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome |
|---|---|---|---|
| 033147 - Deceased Child, Female, 003 Year(s) | 033002 - Mother, Female, 31 Year(s) | Inadequate Guardianship | Substantiated |
| 033147 - Deceased Child, Female, 003 Year(s) | 033002 - Mother, Female, 31 Year(s) | DOA / Fatality | 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?** | ☒ | ☐ | ☐ | ☐ |
| **Did the investigation adhere to established protocols for a joint investigation?** | ☒ | ☐ | ☐ | ☐ |
| **Was there timely entry of progress notes and other required documentation?** | ☐ | ☒ | ☐ | ☐ |

**Additional information:**

Throughout the investigation, ACS did not enter notes contemporaneously. There were large gaps between the event and the entering of the Progress notes.

## 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:**
There was no removal regarding the SS. On 5/23/16 ACS completed intake for a neglect petition against SM. On this date the assigned attorney delayed filing of the case based on the need for additional information. SM had no prior history and was willing to comply with services (the SC's death is a result of a motor vehicle accident).

## 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** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Additional information, if necessary:**
ACS followed up with community based services through the hospital. ACs also learned that All Children's House Child Parent Psychotherapy Preventive Program (ABC) PPRS agency was assigned to the case. ACS learned on 7/15/16 the service provider met with the family face to face and a service plan was discussed to focus on SS and BF with Child/Parent Therapy.

**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:**
ACS documented that the SS was referred to weekly play therapy to address immediate needs and support in response to the fatality.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
ACS documented that the SM and BF were referred to Sauti Yetu's community based organization to address immediate needs related to the fatality.

## 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 are no cases more than three years prior to the fatality.

### Known CPS History Outside of NYS

There is no known CPS History outside of NYS.

### 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

### Additional Local District Comments

There are no additional local district comments.

### 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