Child Fatality Report

Report Identification Number: SY-19-038

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

Issue Date: Dec 04, 2019

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 | **Jurisdiction:** St. Lawrence | **Date of Death:** 07/09/2019
Age: 1 year(s) | **Gender:** Male | **Initial Date OCFS Notified:** 07/17/2019

Presenting Information

An SCR report alleged on 7/9/19, the mother unloaded groceries from her car and was not adequately supervising the two-year-old subject child. The child ran into the road and was hit by a truck. The child died on the scene from the impact of the truck. The roles of the father and five-year-old sibling were unknown.

Executive Summary

This fatality report concerns the death of the one-year-old male subject child who died on 7/9/19. A report was made to the SCR on 7/17/19 regarding the death. The child died as a result of being struck by a vehicle that was traveling on a roadway. There were two surviving siblings, aged two and four years, who lived in the home, who were assessed to be safe during the investigation. The father had another child who resided outside of the home. The sibling's relationship with the father remained unknown.

St. Lawrence County Department of Social Services (SLCDSS) coordinated with law enforcement during the investigation; law enforcement had investigated the fatal incident immediately following the death. LE did not seek criminal charges. It was learned the district attorney was notified of the death on the night of the incident. An autopsy was performed, and the manner of death was listed as "cerebral avulsion, due to depressed skull fractures. Contributing factors also include laceration of thoracic aorta and cervical spinal cord laceration." The coroner ruled the manner of death as an accident.

The parents reported the two-year-old sibling and subject child were outside in a homemade playpen while the father brought groceries into the home. The children were outside unsupervised for several minutes before the two-year-old sibling came inside. When the father went outside to check on the child, he observed the child was not in the playpen and saw commotion in the roadway. The father realized the child was struck by a vehicle and was lifeless in the road. The mother, who was inside at the time of the fatal incident confirmed the father's recollection of the event.

The driver of the vehicle, his partner and a passerby stopped, 911 was called and EMS and law enforcement responded. Law enforcement was the first on scene and began lifesaving measures. EMS arrived soon thereafter and took over CPR. An EMT performed CPR; however, ceased resuscitation efforts as it was apparent the child was dead.

SLCDSS gathered information regarding the incident and death from the parents, the driver and others present at the scene, EMS, the medical examiner and coroner, and law enforcement. Collateral contacts did not express concerns for the care of the surviving children.

Multiple home visits were made, and an abundance of services were offered to the family. The father was attending counseling at the time of case closure; however, the mother was not yet ready to utilize counseling services. SLCDSS also offered services to the witnesses of the fatal incident.

SLCDSS completed all Safety Assessments and required reports timely. Although safety of the siblings was assessed during the investigation, and the children were seen within the first 24 hours of the investigation, the record did not reflect SLCDSS addressed the pressing concerns of supervision with the parents immediately following receipt of the SCR report. SLCDSS added the allegations of DOA/Fatality, Inadequate Guardianship and Lack of Supervision against the father regarding the subject child. Both parents were appropriately substantiated regarding the allegations. The

investigation revealed the parents did not make an appropriate supervision plan for the children, and the child was able to escape the playpen, went in the road and was struck and killed by a passing vehicle.

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

Explain:
Although supervision regarding the surviving siblings was discussed with the parents prior to case closure, the record did not clearly reflect supervision plans regarding the children were explored immediately upon receipt of the SCR report.

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? — No

Was there sufficient documentation of supervisory consultation? — Yes, the case record has detail of the consultation.

Explain:
The decision to close the case was appropriate.

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: 07/09/2019 **Time of Death:** 07:45 PM

Time of fatal incident, if different than time of death: 06:21 PM

County where fatality incident occurred: St. Lawrence
Was 911 or local emergency number called? Yes
Time of Call: 06:21 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☐ Asleep
- ☒ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ Other:

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	33 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)

LDSS Response

On 7/17/19, SLCDSS received an SCR report regarding the death. SLCDSS immediately began their investigation by attempting home visits and contacted the source of the report. Within the first 24 hours of the investigation, SLCDSS checked CPS history and contacted LE.

On 7/18/19, LE said they were involved the night of the incident. The officer reported the child and a sibling were outside of the house, inside of a low-to-the-ground garden fence approximately one foot high. During the investigation, another officer said the playpen was of two arched garden fences attached on top of one another and estimated the playpen to be two feet high. The officer said the father reported carrying groceries inside and the mother was inside at the time of the accident. The father continued to carry groceries inside for a few minutes, and when he saw the two-year-old sibling inside, the father went to check on the subject child. The father saw the child was in the road and was struck by a vehicle.

Contact was made with the family in their home on 7/18/19. The siblings were observed, and the home was assessed to be safe. The caseworker offered bereavement services and provided information for hospice services. A home visit was made on 7/19/19 and the four-year-old sibling said the child went into the road after he ran away. The parents corroborated with LE's information regarding the father bringing in groceries while the mother was inside. The father said the two-year-old sibling and the child were outside playing while the four-year-old sibling was inside sleeping. The father checked on the sleeping sibling and saw the two-year-old sibling was inside. The father went to check on the child and he was not inside of the playpen. The child escaped the playpen, traveled down the driveway and into the road where he was struck and killed by a passing vehicle. The parents said usually one parent watched the children while the other carried in the groceries; however, there was not communication about supervision that day. The father said the child ran toward the road twice that day and was spanked as a result.

Through conversations and LE records, SLCDSS obtained information regarding the incident and the death. A neighbor and the driver's partner said the children often played in the yard with their parents and saw the child running toward and playing near the road in the past and the parents were chasing after them. An officer was flagged down by a passerby and the driver's partner. The officer saw the father holding the child and the mother said the child got out of the playpen. The child was bleeding from the ears and had a bleeding head-wound with abrasions and bruises about his body. The officer applied an AED to the child, but no shock was advised. EMS responded and took over resuscitation efforts for five minutes before stopping lifesaving measures. The child was pulseless, not breathing and was observed to have severe blunt force trauma with multiple fractures to his torso and skull. The coroner reported to the scene and pronounced the child deceased at 7:45 PM. The driver was interviewed and stated he thought he hit an animal but looked in his rear-view mirror and saw the body of a small child. He stopped and dialed 911. The driver did not see the child prior to the accident. The driver participated in standard field sobriety testing and was not found to be impaired.

An abundance of services and referrals were offered to the family including grief counseling, mental health counseling and other hospice services. The father was engaged in counseling, and the mother was utilizing her church for support. The child's funeral was funded by the funeral home.

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
Comments: The death was referred to Child Fatality Review Team during the course of the investigation.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
051879 - Deceased Child, Male, 1 Yrs	051907 - Father, Male, 33 Year(s)	Lack of Supervision	Substantiated
051879 - Deceased Child, Male, 1 Yrs	051906 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated

051879 - Deceased Child, Male, 1 Yrs	051906 - Mother, Female, 27 Year(s)	Lack of Supervision	Substantiated
051879 - Deceased Child, Male, 1 Yrs	051907 - Father, Male, 33 Year(s)	DOA / Fatality	Substantiated
051879 - Deceased Child, Male, 1 Yrs	051907 - Father, Male, 33 Year(s)	Inadequate Guardianship	Substantiated
051879 - Deceased Child, Male, 1 Yrs	051906 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
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?	☒	☐	☐	☐

Explain: The record did not reflect discussions with the parents regarding the pressing concern of supervision at the initial home visit.

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?	☐	☐	☒	☐
Explain: Although the siblings were seen within the first 24 hours of the investigation, the record did not reflect a supervision plan moving forward at that time. Prior to case closure, the record reflected the parents would both be outside if the children were outside, and there would be clear communication if one parent needed to go inside.				

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: SLCDSS offered an abundance of services to the family including mental health counseling, grief and bereavement services, funeral assistance and hospice services. Additionally, services were offered to the first responders and witnesses of the fatal incident.				

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: No children needed to be removed as a result of the 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	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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
SLCDSS offered a multitude of services to the family. The family was offered grief services through a local hospice program, which the family was accepting of; however, only the father was utilizing the services at the time of case closure.

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:
The family was offered bereavement services 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:
The parents were offered an abundance of services in response to the fatality.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	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

7/23/07- 1/3/08 The father was substantiated for Inadequate Guardianship and Lack of Supervision regarding other children.

Known CPS History Outside of NYS

Although the family resided outside of New York and records were requested from Ohio, no documentation was received prior to case closure. It remained unknown if the family had a CPS history outside of New York State.

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