Child Fatality Report

Report Identification Number: NY-21-112

Prepared by: New York City Regional Office

Issue Date: Apr 12, 2022

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: 2 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 10/24/2021
Initial Date OCFS Notified: 10/25/2021

Presenting Information

The SCR report alleged on 10/24/21, at about 8:25 PM, the mother was not adequately supervising the two-year-old female child when she took the child out of the car that they were in and put her on the sidewalk. The mother then turned around toward the car to get packages out of the car. During this time, the child ran toward the front of the vehicle, and was hit by the car as it drove off. The child was brought to the hospital with the mother in a private vehicle about 30 minutes later, at approximately 8:55 PM. Upon arrival to the hospital, the child was unresponsive to pain and had no pulse. The child had bruises to the left side of her face, bleeding through her nose, mouth and ears, general swelling to her head, a protruded abdomen, and bruising to her left lower quadrant. Cardiopulmonary resuscitation began and continued until approximately 10:00 PM, when she died as a result of her injuries.

Executive Summary

This fatality report concerns the death of the 2-year-old child that occurred on 10/24/21. As of 3/22/22, NYCRO had not yet received a copy of the autopsy report from the medical examiner.

At the time of the incident the child resided with her mother. There were no surviving siblings or other children in the home.

ACS' investigation revealed on 10/24/21, at 8:36PM, the mother and her boyfriend pulled up in front of the mother's residence after going shopping. The boyfriend, who was driving the vehicle, remained in the car, while the mother exited the car with the child and began to retrieve her bags from the trunk. After retrieving her bags, the mother said goodbye to her boyfriend from the trunk/hatch. The boyfriend then closed the hatch, backed up, and pulled forward. During this time, the child ran in front of the vehicle. The car was in a forward motion and drove over the child. The boyfriend came out of the car as the mother ran to the front of the car and picked up the child. The adults returned to the vehicle with the child and drove to the hospital. CPR was performed by medical team at the hospital; however, efforts were unsuccessful, and the child was pronounced dead at 10:00 PM.

ACS contacted law enforcement and learned the boyfriend was interviewed. His account was corroborated by the video footage that was obtained from security systems in the area. Law enforcement confirmed there were no other children in the home and that the mother's boyfriend did not reside in the home. Law enforcement further indicated their investigation was ongoing; however, the incident appeared to be accidental.

Medical collaterals indicated the adults brought the child to the hospital at 8:55PM. At the time the child arrived, she was non-responsive, she did not have a pulse, and did not respond to multiple attempts to resuscitate her. The physician who treated the child provided the account the adults had shared, and the account was consistent with information from law enforcement. The physician indicated the adults had gone to another hospital prior to arriving at the hospital where the child was pronounced dead, but were not allowed into the facility. When the Specialist inquired about injuries, the physician explained there was a noticeable deformity to the child's head on both sides as well as the child bleeding from both her ears, nose and mouth, a scrape/abrasion to the left side of the child's face, bruising to the lower left stomach and the child's belly was distended.

ACS contacted family members who expressed shock at the death of the child. ACS learned the family contacted the father of the child who was away in the military. ACS also interviewed neighbors, conducted home visits, interviewed the

mother, and offered her services including bereavement services. The mother declined services.

ACS substantiated the allegations of DOA/Fatality, Lack of Supervision, Lacerations/Bruises/Welts, Internal Injuries, Swelling/Dislocation/Sprains, and Inadequate Guardianship of the child by the mother on the basis that credible evidence was gathered that she placed the child in imminent danger when she failed to provide adequate supervision and the child was struck by the vehicle driven by the mother's boyfriend. To support this decision, ACS documented that video evidence was observed which captures the mother retrieving bags from the trunk of her boyfriend's car while failing to adequately supervise the child. As a result, the child ran in front of the car and was struck as the mother's boyfriend drove the car forward.

ACS added and substantiated the allegation of Lack of Medical Care against the BM. ACS documented that when the child was struck by the car the mother did not contact 911; instead, she drove the child to the hospital arriving 30 minutes after the incident occurred.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

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:
Sufficient information was gathered to make determination for all allegations on the intake report.

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 level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion, 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: 10/24/2021 **Time of Death:** 10:00 PM

Date of fatal incident, if different than date of death: 10/25/2021
Time of fatal incident, if different than time of death: 08:36 PM

County where fatality incident occurred: Queens
Was 911 or local emergency number called? No
Did EMS 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: Outside with her mother.

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:

- ☒ Distracted
- ☐ Absent
- ☐ Asleep
- ☒ Other: **Removing bags from the vehicle.**

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	Female	2 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Mother's Partner	No Role	Male	23 Year(s)

LDSS Response

On 10/25/21, ACS received the fatality report from the SCR. Within the first 24 hours of the investigation, ACS completed a CPS history check, contacted the source of the report, interviewed neighbors, notified the district attorney and medical examiner's offices of the death, conducted a home visit and coordinated the investigation with law enforcement.

On 10/25/21, ACS contacted medical personnel and learned at about 8:55PM on 10/24/21, the mother came to the hospital with the child. The child was non-responsive and did not have a pulse. The physician stated multiple attempts were made to resuscitate the child; however, none were successful and the child was pronounced dead. The physician said according

to the mother, the child was on the sidewalk with her as she was taking groceries out of the trunk of the car. The child ran in front of the vehicle and when the boyfriend pulled off there was a loud thump. When she and her boyfriend went to check, they noticed it was the child. They got into the car and rushed to the hospital. The physician said the mother reported she had tried another hospital before but they were not allowed into the facility. The child was declared dead at 10:00PM.

When the team inquired about injuries, the physician explained there was a noticeable deformity to the child's head on both sides as well as the child bleeding from both her ears, nose and mouth, a scrape/abrasion to the left side of the child's face, bruising to the lower left stomach and the child's belly was swollen. The physician said the BM did not appear to be under the influence of any substances. He explained the mother's account was consistent with the child's injuries of the child and there was no sign of abuse.

ACS interviewed the mother who explained she was with the child as they got out of the car. The child was on the sidewalk. The mother said as she was grabbing bags from the car, the child ran in front of the car and got struck by the driver as they drove off.

On 10/25/21, ACS contacted the mother's neighbors. A neighbor reported his security system had captured the incident and the information was turned over to law enforcement. The neighbor declined to share the video with ACS. The neighbor stated that the car was an SUV and there was no way the driver saw the child near the car before pulling out

On 10/25/21, the maternal grandmother confirmed that the child was the mother’s only child .

On 10/26/21, detectives stated the case was under investigation but there was no criminal intent regarding the death of the child. The detectives indicated video footage corroborated the statements provided by the mother and her boyfriend.

Upon completion of the investigation, ACS substantiated the allegations of the report and indicated the case. The mother declined 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)?Yes

Was the fatality referred to 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
060062 - Deceased Child, Female, 2 Yrs	060063 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
060062 - Deceased Child, Female, 2 Yrs	060063 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated

060062 - Deceased Child, Female, 2 Yrs	060063 - Mother, Female, 23 Year(s)	Internal Injuries	Substantiated
060062 - Deceased Child, Female, 2 Yrs	060063 - Mother, Female, 23 Year(s)	Lacerations / Bruises / Welts	Substantiated
060062 - Deceased Child, Female, 2 Yrs	060063 - Mother, Female, 23 Year(s)	Lack of Supervision	Substantiated
060062 - Deceased Child, Female, 2 Yrs	060063 - Mother, Female, 23 Year(s)	Swelling / Dislocations / Sprains	Substantiated
060062 - Deceased Child, Female, 2 Yrs	060063 - Mother, Female, 23 Year(s)	Lack of Medical Care	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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The mother declined services.

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? N/A
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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