Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-20-040

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

Issue Date: Mar 15, 2021

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	

Case Information

Report Type: Child Deceased
Age: 2 year(s)
Jurisdiction: Dutchess
Gender: Female
Date of Death: 10/08/2020
Initial Date OCFS Notified: 10/08/2020

Presenting Information

An SCR report alleged that on 10/8/20, the mother and parent substitute failed to properly secure the 2-year-old child's car seat in the vehicle. The parent substitute was driving with the mother and child and the family's vehicle was involved in an accident during which they were rear ended. As a result, the child hit the back of the driver's seat and sustained severe head trauma. It was unknown whether the child came out of the car seat. The child was transported to the hospital in an unknown manner. At 3:49 PM, the child passed away from intracranial hemorrhage due to the severe head trauma. The role of the father was unknown.

Executive Summary

On 10/8/20, the Dutchess County Department of Community and Family Services (DCDCFS) received an SCR report regarding the death of the 2-year-old female child. At the time of the child's death she resided with her mother, 5-year-old sibling, and maternal great grandparents. The child's father shared custody with the mother and he resided with his partner, their 1-month-old infant and the paternal grandmother. The 5-year-old sibling's father resided next door to the mother and he shared custody of the 5-year-old sibling.

DCDCFS conducted a joint investigation with law enforcement and they learned that on 10/8/20 at 8:18 AM, the mother was on her way to drop the child off at the father's home. The child was strapped into her car seat in the rear driver's side of the vehicle. The 5-year-old sibling was at her father's home at the time. The mother's vehicle was stopped behind a law enforcement vehicle that was making a left turn, when her car was rear ended by an SUV that was going approximately 55 mph. The officer called 911 and law enforcement cut the straps that tethered the car seat to the car and removed the child from the vehicle, still strapped into her car seat. The child's face was bleeding and began to swell. The mother called the father and he arrived at the scene. The mother and child were transported to the hospital in separate ambulances and the child was treated for seizures on the way. The mother and child were then airlifted to a second hospital, where the child underwent emergency surgery on her skull to relieve the pressure. The child became unstable during surgery and she was placed on a ventilator. The child's condition continued to decline, and despite life-saving measures, she was pronounced deceased at 3:49 PM. The mother suffered only minor injuries, although she was 8 months pregnant, so she was briefly hospitalized to monitor the unborn child.

DCDCFS thoroughly investigated the incident by speaking to both professional and familial collaterals. The siblings were assessed to be safe with their parents and there were no concerns for their care. The mother's partner was alleged to have been in the vehicle at the time of the accident, although it was determined he was not in the car. He did not reside in the mother's home and he had no concerns for the children.

DCDCFS obtained a copy of the Medical Examiner's final report, which stated "based on an investigation and a postmortem examination without autopsy, the cause of death has been certified as blunt force injury of head, accident, rear seat passenger in car that was rear ended while stopped, State Route 22 Amenia, Dutchess County, New York on 10/08/20 at 8:18 AM." At the time the case was closed, no charges had been filed and the law enforcement investigation remained open pending the final report of the accident reconstruction.

DCDCFS unsubstantiated the allegations against the mother as the investigation revealed that the child was restrained in a car seat with a 5-point harness, and it was properly installed in the vehicle. First responders reported that there was

nothing the mother could have done differently to prevent the accident or the child's death. The family was provided with funeral assistance and they declined bereavement services. The case closed on 11/24/20.

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:
Evidence gathered supported the decision to unsubstantiate the allegations and close the case.

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:
Casework activity was commensurate with best casework practice.

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: 10/08/2020 **Time of Death:** 03:49 PM

Child Fatality Report

Time of fatal incident, if different than time of death: 08:18 AM

County where fatality incident occurred: Dutchess
Was 911 or local emergency number called? Yes
Time of Call: 08:18 AM
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

Did child have supervision at time of incident leading to death? Yes
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	Deceased Child	Alleged Victim	Female	2 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	67 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	71 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Other Household 1	Mother's Partner	Alleged Perpetrator	Male	28 Year(s)
Other Household 2	Father	No Role	Male	25 Year(s)
Other Household 2	Father's Partner	No Role	Female	25 Year(s)
Other Household 2	Grandparent	No Role	Female	57 Year(s)
Other Household 2	Sibling	No Role	Male	1 Month(s)
Other Household 3	Other Adult - 5-year-old Sibling's Father	No Role	Male	27 Year(s)
Other Household 3	Other Adult - 5-year-old Sibling's Uncle	No Role	Male	25 Year(s)

LDSS Response

DCDCFS investigated the incident by searching SCR history and speaking to the source of the report, law enforcement, staff at both hospitals, the medical examiner, the fathers of the children and several family members. DCDCFS received a copy of the 911 call, the child's hospital records and the mother's prenatal records. On the day of the accident, the mother and her partner were interviewed at the hospital and the siblings were assessed to be safe with family members. DCDCFS assessed the homes of the mother, father and 5-year-old sibling's father to be safe.

During interviews with the mother she stated that she was dropping the child off at her father's home on her way to work. The law enforcement vehicle traveling in front of her stopped to make a left turn, so she came to a complete stop. The

officer had just completed the turn when she was struck from behind by an SUV. The rear end of the vehicle was crushed, and the back seat pushed forward, causing the child's face to hit the driver seat. The officer witnessed the accident and he came to assist the mother and child. The child's door was unable to be opened and the child had to be removed from the vehicle through the passenger side rear door. The other driver told her he didn't see her vehicle stopped. She called the father to inform him of the accident and he came to the scene. The father rode with the child to the first hospital in the ambulance and then in the helicopter with the child to the second hospital. The father kept the mother updated on the child's condition and he informed her that the child was having seizures and she needed to have emergency surgery to relieve the pressure on her brain. The mother was informed the child was not going to make it and she was able to say goodbye to the child.

The father reported that the child was still in her car seat in the car when he arrived at the scene. He had previously assisted the mother with installing the car seat in the vehicle and he said the mother always properly restrained the child.

The law enforcement officer who witnessed the accident reported that the mother did nothing wrong. He observed the other driver coming up behind the mother at a good rate of speed and he did not brake prior to colliding with the mother's car. The car seat was properly restrained in the rear driver side of the mother's vehicle. A second law enforcement officer reported that the speed limit was 55 mph. The vehicle that hit the mother's vehicle was a larger older model SUV. The other driver saw the law enforcement vehicle turning left but it was believed the driver did not see the mother's vehicle. The rear driver's side of the mother's vehicle received the most damage and the air bags did not deploy. The child's car seat was cut out of the vehicle and she was not removed from the car seat until she arrived at the first hospital. There were no concerns for the child not being properly restrained.

Hospital staff reported that upon arrival the child was having seizures, she was in respiratory failure, and she was diagnosed with a traumatic head injury. The child was transported to a second hospital for a higher level of care. Records at the second hospital showed that the child underwent emergency craniotomy surgery, however the procedure was stopped prematurely due to cardiac arrest. The child was transferred to the Pediatric Intensive Care Unit where chest compressions and medication were given, however her "vital signs continued to decline despite maximum support" and the child was pronounced deceased at 3:49 PM.

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?No
Comments: Dutchess 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
056539 - Deceased Child, Female, 2 Yrs	056544 - Mother's Partner, Male, 28 Year(s)	Inadequate Guardianship	Unsubstantiated

056539 - Deceased Child, Female, 2 Yrs	056544 - Mother's Partner, Male, 28 Year(s)	Internal Injuries	Unsubstantiated
056539 - Deceased Child, Female, 2 Yrs	056540 - Mother, Female, 26 Year(s)	DOA / Fatality	Unsubstantiated
056539 - Deceased Child, Female, 2 Yrs	056540 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
056539 - Deceased Child, Female, 2 Yrs	056544 - Mother's Partner, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
056539 - Deceased Child, Female, 2 Yrs	056540 - Mother, Female, 26 Year(s)	Internal Injuries	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 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: The family accepted funeral assistance and they declined bereavement services.				

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?	☐	☒	☐	☐

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 siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
No service needs were identified for the siblings related 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 provided with funeral assistance and provided with information on bereavement 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? 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 was 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 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