Report Identification Number: NY-22-060

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

Issue Date: Jan 26, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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
Age: 4 year(s)

Jurisdiction: Bronx
Gender: Male

Date of Death: 08/14/2022
Initial Date OCFS Notified: 08/15/2022

Presenting Information

An SCR report dated 8/15/22, alleged on 8/14/22 at approximately 9:22PM, the father, was speeding while driving his moped with the child, seated on his lap. The child was not restrained in a seat belt and was not wearing a helmet. A car was turning left when the motorized scooter struck the car. The child was pinned under the motorized scooter and sustained internal injuries, trauma, and died as a result. The mother had an unknown role.

Executive Summary

On 8/15/22, New York City Administration for Children's Services (ACS) received an SCR report regarding the death of the 4-year-old male subject child. At the time of the death, the child was visiting with his father and resided with his mother. There were no surviving siblings.

ACS learned the father took the child for a ride on a motorized scooter and the child was not wearing a helmet or proper safety equipment. The child was thrown from the motorized scooter after being struck by another vehicle. A bystander called 911, first responders arrived, began life saving measures and transported the child to the hospital. Hospital staff continued life-saving measures but were unsuccessful and the child was pronounced deceased at 10:15PM.

ACS contacted the medical examiner's office, and an autopsy was performed; however, the final report was pending further testing at the time this report was written. The medical examiner stated the preliminary cause of death was blunt force trauma and the manner of death was accident. Law enforcement investigated the incident and reported the motorized scooter did not belong to the father; it was reported stolen. The father was arrested and criminally charged with endangering the welfare of a child and felony criminal possession of stolen property. At the time this report was written, the criminal case remained open.

ACS substantiated the allegations of DOA/Fatality, Internal Injuries, and Inadequate Guardianship against the father regarding the death of the child. ACS found the father placed the child in danger by riding him on a motorized scooter without the adequate safety equipment. As a result of the accident on the motorized scooter the child sustained multiple injuries that contributed to his death. ACS unsubstantiated the allegation Parent's Drug Alcohol Misuse; there was no evidence the father was under the influence of any substance at the time of the fatality. ACS offered the parents grief counseling, mental health counseling and burial assistance, and they declined the services.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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?** 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 made an appropriate determination based on the evidence obtained throughout the investigation.

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 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: 08/14/2022 **Time of Death:** 12:15 AM

Time of fatal incident, if different than time of death: 10:15 PM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 09:21 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☒ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ 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	4 Year(s)
Deceased Child's Household	Mother	No Role	Female	25 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	24 Year(s)

LDSS Response

On 8/15/22, ACS received a report regarding the death of the subject child. ACS initiated their investigation within 24 hours and contacted the source of the report. ACS completed a history check regarding the family and informed the DA of the fatality. ACS contacted the mother and spoke with relatives on 8/15/22. There were no surviving children.

ACS interviewed the mother, father, paternal grandparents, and two paternal aunts' regarding the incident that led to the child's death. ACS learned the father and child left the grandparents' home on foot in the afternoon. Family members reported the father did not own a motorized scooter and the child did not own a helmet or other protective gear for a motorized scooter. The child was visiting the father for the week at the time of the fatal incident. The father reported the child asked him to go for a ride on the motorized scooter a friend was riding. The father took the child for a spin around the block and the child asked to go again. The father reported a car was making a U-turn, cut him off and hit him and the child on the motorized scooter. The father reported the child was wearing a helmet at that time. There was no evidence found that the child was wearing a helmet at the time of the fatality. The mother told ACS she was unaware the father was riding the child on a motorized scooter, or that he owned one. The mother did not own a helmet for the child and was unaware if the father had any protective gear for the child.

At the close of the investigation, the medical examiner reported the child's preliminary autopsy cause of death was blunt force trauma and the manner of death accident. The final autopsy report was pending at the writing of this report.

ACS contacted numerous collateral sources including law enforcement, hospital staff, EMS, and the child's pediatrician. When first responders arrived at the scene, the child was unresponsive and had no pulse. Hospital staff informed ACS the child suffered from cardiac arrest due to his injuries. Law enforcement administered sobriety tests to the father and there were no signs of impairment at the time of the fatal incident. The father was arrested, and criminal charges were filed against him. At the time this report was written, the criminal case remained open.

Services were offered to the family and were declined. ACS appropriately unsubstantiated the allegation of PD/AM against the father regarding the child; there was no evidence the father was impaired while driving the motorized scooter. ACS found evidence to support the allegations of DOA/Fatality, Internal Injuries and Inadequate Guardianship in the report and appropriately indicated and closed the investigation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending

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: ACS does not have an OCFS approved Child Fatality Review Team

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061295 - Deceased Child, Male, 4 Yrs	061296 - Father, Male, 24 Year(s)	DOA / Fatality	Substantiated
061295 - Deceased Child, Male, 4 Yrs	061296 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
061295 - Deceased Child, Male, 4 Yrs	061296 - Father, Male, 24 Year(s)	Internal Injuries	Substantiated
061295 - Deceased Child, Male, 4 Yrs	061296 - Father, Male, 24 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Endangering the welfare of a child **Degree:** NA			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
08/14/2022	the father	Unknown	pending
Comments:	The criminal case remained open at the writing of this report.		

Criminal Charge: Other - Criminal Possession of Stolen Property **Degree:** 4			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
08/14/2022	the father	Unknown	pending
Comments:	The criminal matter remained open at the writing of this report.		

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:
There were no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS offered mental health counseling, burial assistance and bereavement services and the family declined.

History Prior to the Fatality

Child Information

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/17/2021	Deceased Child, Male, 2 Years	Father, Male, 23 Years	Inadequate Guardianship	Substantiated	Yes

Report Summary:
An SCR report dated 6/17/21, alleged the father was riding an electric motor bike on the sidewalk, bobbing, and weaving through people, with the then 2-year-old subject child on the motorbike. The child did not have on a helmet or protective gear. The child was unharmed. The mother had an unknown role.

Report Determination: Indicated | **Date of Determination:** 08/16/2021

Basis for Determination:
The allegation of IG was substantiated against the father. The fathers' actions placed the child at risk of harm. ACS attempted to file a neglect petition against the father; however, there was insufficient evidence to file the petition. Preventive Services were offered, and the father declined the services.

OCFS Review Results:
The investigation was initiated timely, and the source of the report was contacted. Home visits were made, and collaterals were contacted. The 7-day safety assessment was completed inaccurately, and written notice of the SCR report were

provided untimely to the parents. The paternal grandparents and the paternal aunt did not receive written notice of the report although they resided in the home.

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

Issue:
Failure to provide notice of report
Summary:
The record reflected that Notice of Existence letters were sent untimely, on 8/4/21, to the mother and father. The record did not reflect the other adults that resided in the home were sent written notice of the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Failure to Provide Notice of Indication
Summary:
The record did not reflect that ACS provided Notice of Indication letters to the other adults listed in the report.
Legal Reference:
18 NYCRR 432.2(f)(3)(xi)
Action:
ACS shall deliver or mail to the subject(s) and other persons named in the indicated report, except children under the age of 18 years, a written notification, within seven days of the determination, in such form as required by OCFS.

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The safety assessments reflected the father had an apparent or diagnosed medical or mental health status that negatively impacted his ability to protect the child; however, the father had no mental health diagnosis, was not engaged in mental health treatment, denied mental health issues or cognitive delays, and the completed RAP reflected no mental health or medical impairments.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
The results of each safety assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

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