Child Fatality Report

Report Identification Number: RO-24-014

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

Issue Date: Jan 07, 2025

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: 1 year(s)
Jurisdiction: Seneca
Gender: Male
Date of Death: 07/16/2024
Initial Date OCFS Notified: 07/16/2024

Presenting Information

An SCR report was received that alleged on 7/16/24 at 6:09PM, the mother left the 1-year-old subject child in the driveway. The mother got into the vehicle and put the car in reverse unaware that the subject child was in the driveway. The mother hit the subject child, and he sustained multiple fractures to various areas of his body such as his arms and skull. The mother contacted the father, and the father called 911. The mother picked up the subject child's body and held him while sitting on the porch until emergency services arrived. Emergency responders arrived at the home at 6:16PM. After evaluation, it was determined the subject child was killed on impact from the vehicle and was pronounced deceased at 6:19PM at the scene.

Executive Summary

On 7/16/24, Seneca County Department of Human Services (SCDHS) received an SCR report regarding the death of the 1-year-old male child. The SCR report contained allegations of DOA/Fatality, Fractures, and Inadequate Guardianship against the subject mother regarding the subject child. At the time of his death, the subject child resided with the subject mother, father, and surviving siblings ages 10, 8, 6 and 4 years old. SCDHS immediately assessed the safety of the surviving siblings and determined they were safe in the care of their parents. SCDHS initiated a safety plan with the parents surrounding appropriate levels of supervision and appropriate use of care seats and safety restraints when transporting the children.

Through a joint investigation with law enforcement, it was learned that on 7/16/24, the subject child was in the care of his mother. Around 6:09PM, the mother carried the subject child outside and placed him down on the ground. The mother proceeded to get the surviving siblings into the car and then put the vehicle in reverse. While the vehicle was backing out of the driveway, the mother drove over the subject child. The mother immediately contacted the father who then contacted 911. Emergency medical services and law enforcement responded to the home. The subject child was pronounced deceased at the residence.

SCDHS communicated with the county coroner and learned an autopsy was not performed due to religious beliefs. An external examination was completed and revealed the subject child's cause of death was "crush injury to the head and upper trunk."

SCDHS communicated with law enforcement and learned there were no criminal charges pending against the mother. The criminal investigation was closed as it appeared the incident was an accident.

SCDHS substantiated allegations of Inadequate Guardianship, Fractures and DOA/Fatality against the mother. SCDHS found that the actions or inactions of the mother contributed to the subject child's death. The mother placed the subject child on the ground and failed to ensure he was in the vehicle before placing the car in reverse and subsequently drove over the child. The 24-Hour and 30-Day fatality reports were completed timely and accurately. Safety Assessments were done timely and accurately; however, there was no 30-Day Safety Assessment completed in Connections. The Risk Assessment Profile was consistent with case circumstances. SCDHS contacted numerous collateral contacts such as family members, the pediatrician, school, EMS, the county coroner, and law enforcement.

Bereavement services were discussed, and information was provided to the mother and father. In addition, the family reported any supportive services needed they would seek through their community. The record did not reflect burial assistance being discussed with the family.

PIP Requirement

SCDHS will submit a PIP to the Rochester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the SCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDHS 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:**
  - **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:

SCDHS made an appropriate decision to substantiate the allegations of DOA/Fatality, Fractures and Inadequate Guardianship based on evidence obtained throughout their investigation.

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:

Casework activity was not commensurate with case circumstances as the 30-Day Safety Assessment was not completed in Connections.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	There was no 30-Day Safety Assessment completed in Connections.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	A safety assessment will be documented and approved by a supervisor within 30 days of a report if such report contains the allegation of DOA/Fatality, as required.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/16/2024 **Time of Death:** 06:19 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Seneca
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
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	1 Year(s)
Deceased Child's Household	Father	No Role	Male	33 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)

Deceased Child's Household	Sibling	No Role	Female	6 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)

LDSS Response

Upon receipt of the SCR report, SCDHS initiated their investigation within 24 hours, completed a CPS history check, and coordinated their efforts with LE, the coroner, and DA. SCDHS immediately assessed the SSs to be safe in the care of their parents.

SCDHS interviewed the SM at the home. During her interview, she explained at the time of the incident, she was getting ready to go to the family farm to complete chores, which was a daily occurrence. The SM reported she walked out to the vehicle, which she reported was a van and was holding the SC. The SM explained she opened the side door and noticed the inside of the vehicle was hot, so she put the SC down on the ground and started the vehicle to cool it down. The siblings then got into the vehicle. The SM noted she "normally" checks that all the children are buckled prior to driving. The SM explained she did not see any children outside of the vehicle when she put the vehicle into reverse. While reversing, the SM felt a "slight bump and then a larger bump" and believed she had reversed over a "stone." The SM then exited the vehicle and went to the front of the vehicle and reported not seeing anything and then turned and saw the SC. The SM explained she screamed, picked up the SC and carried him to the porch, and told the siblings to bring her cell phone. At that time, the SM contacted the father and continued sitting on the porch with the children. The SM reported within a few minutes EMS arrived and the paternal grandmother who took the surviving siblings inside the home. The SM noted when the siblings got into the vehicle they were talking and no one noticed that the SC was not in the vehicle.

SCDHS interviewed the BF at the home. During his interview, he explained he was not home at the time of the incident as he was working at the family farm. The father reported every night the mother and children arrive at the farm to help complete chores, and he was expecting their arrival. The father explained the mother contacted him via phone and told him she backed over the SC and she thought he was deceased. The father reported he immediately contacted 911 and drove home noting he arrived before emergency medical services. When the father arrived, he was still on the phone with 911 who instructed him to attempt CPR, but the father reported to the operator it was clear the subject child was deceased as his body was "completely limp."

SCDHS interviewed the surviving siblings at the home. The siblings reported not being comfortable discussing the incident with the SC; however, SCDHS was able to discuss basic safety and risk related questions. There were no concerns noted from any of the children regarding their care or for their parents.

SCDHS communicated with the law enforcement officer who was the first to respond to the scene. Upon arrival, law enforcement observed the SM sitting with the SC on the porch and the BF was with the siblings next to the vehicle. Law enforcement observed the SC was "pale, cold to the touch and was bleeding from several orifices." Law enforcement explained they checked the SC for a pulse but could not find one. Law enforcement confirmed the SM and BF's recollection of events and reported the incident appeared to be an accident.

Official Manner and Cause of Death

Official Manner: Unknown

Primary Cause of Death: From an injury - external cause

Person Declaring Official Manner and Cause of Death: Coroner

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? Yes

Comments: Seneca County referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069408 - Deceased Child, Male, 1 Year(s)	069409 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
069408 - Deceased Child, Male, 1 Year(s)	069409 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
069408 - Deceased Child, Male, 1 Year(s)	069409 - Mother, Female, 33 Year(s)	Fractures	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?	☐	☒	☐	☐

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 children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☒	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes

Explain:

Bereavement services were discussed with the parents and information was provided to the family. For additional supportive services the family informed CPS they would be working within their religious community.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes

Explain:
Bereavement services were discussed with the parents and information was provided to the family. For additional supportive services the family informed CPS they would be working within their religious community. The record did not reflect burial assistance being discussed with the parents.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)
02/20/2023	Deceased Child, Male, 1 Months	Mother, Female, 32 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Male, 1 Months	Mother, Female, 32 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Male, 1 Months	Father, Male, 31 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 1 Months	Father, Male, 31 Years	Lack of Medical Care	Substantiated	

Report Summary:
An SCR report was received that alleged the then 1-month-old subject child became sick at home. The mother and father used a raspberry tea, and a drink called emergen-C, along with a neighbor's oxygen to treat the subject child. The parents' form of treatment led to increased health risks for the subject child including seizures, dehydration, and electrolyte intolerance. The parents waited 4 days to bring the subject child for medical care, at which point he was suffering from fever and lethargy. The subject child was then placed on a ventilator and was intubated.

Report Determination: Indicated | **Date of Determination:** 03/31/2023

Basis for Determination:
Seneca County Department of Human Services substantiated the allegations of Inadequate Guardianship and Lack of Medical Care against the mother and father. The parents confirmed they gave the subject child medication and remedies that were not prescribed to the subject child or intended to be used for infants, which increased health risks to the subject child. In addition, the parents admitted they did not seek timely medical treatment for the subject child. A safety plan was implemented, and the parents were compliant and were appropriate with the subject child's medical needs.

OCFS Review Results:
Seneca County Department of Human Services immediately initiated their investigation, spoke to the source of the report, and completed a CPS history check. Safety Assessments were completed timely and accurately, and the Risk Assessment Profile was consistent with case circumstances. Required notification letters were provided to the parents.

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

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 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