Child Fatality Report

Report Identification Number: SV-24-049

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

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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 month(s)
Jurisdiction: Dutchess
Gender: Female
Date of Death: 10/28/2024
Initial Date OCFS Notified: 10/29/2024

Presenting Information

An SCR reported received on 10/28/24 alleged that on that same date, the mother and father were driving in a vehicle without the subject child being properly restrained in her car seat. The mother got into an accident. As a result, emergency medical intervention was necessary, as the child sustained injuries and was in critical condition. A subsequent report was received on 10/29/24 regarding the parents' failure to properly restrain the child in the vehicle, the mother driving recklessly and passing another vehicle on a double yellow line, and the mother losing control of the vehicle and hitting a tree. As a result, the child sustained massive traumatic injuries including a skull fracture, brain swelling, and bruising around her right eye. Emergency medical services responded and transported the child to the hospital. The child was pronounced deceased on 10/28/24 at 11:28PM due to the sustained injuries.

Executive Summary

This report concerns the death of the 4-month-old subject child. Dutchess County Department of Community and Family Services (DCDCFS) received an SCR report regarding the fatal incident and subsequent death on 10/28/24 and 10/29/24, respectively. At the time of the child's death, she resided in a shelter with her mother and father.

On 10/28/24, the mother left the shelter with the child around 9:06AM to pick up the father from work. The mother strapped the child into her car seat. Given the child's age, the child required a 5-point harness, rear-facing car seat. A 5-point harness has five straps; two located at the shoulders that secure across the chest, and two at the hips with one at the crotch, that come to connect in a buckle. The mother failed to secure the hip and crotch straps into the buckle, stating the child had eczema or a rash and she did not want the child to be uncomfortable. The mother drove with the child improperly restrained to the father's job, arriving around 10:06AM. The father got into the front passenger seat of the vehicle and the mother proceeded to drive away. The parents became involved in a verbal disagreement while driving. There was a discrepancy in reporting in which the mother stated the father grabbed the steering wheel, causing her to lose control of the vehicle, and the father denied grabbing the wheel and reported the mother kept taking her hands off the wheel and had swerved into oncoming traffic then swerved off the road. The vehicle hit a tree head-on. No one in the vehicle was properly restrained. A bystander called 911 and upon emergency medical services (EMS) arrival, the father was found on the roof of the vehicle, the mother was in the passenger side, and the child was found in a face-down position, toward the foot of the car seat and rear passenger door. The child was heard crying at arrival but shortly after ceased responding. When EMS opened the rear door, there were no visible harness straps across the child, and they were able to lift the child out of the car seat. The child was taken to the ambulance. It was noted the child was unresponsive with left fixed gaze and no pupil response and displayed no reflex responses. Care was turned over to life flight crew and the child was transferred to the hospital, where she was later pronounced deceased at 11:28PM.

The medical examiner was notified and performed an autopsy on the child. The final autopsy report was not yet available. Hospital records indicated a cause of death as cardiac arrest, and the child was diagnosed with traumatic brain injury. Law enforcement investigated and their investigation remained ongoing, pending final autopsy results.

DCDCFS made several home visits to where the parents were temporarily staying, as they did not return to their previous shelter following the accident. DCDCFS interviewed the parents separately, relevant collateral sources, as well as family members close to the parents.

DCDCFS found a fair preponderance of evidence to support substantiating the allegations against the mother regarding the fatal incident and death of the child. Through a thorough investigation, DCDCFS confirmed the mother was the driver of the vehicle when the accident occurred. The mother failed to properly secure the child in the required child safety restraint system (car seat). The mother also failed to drive in a safe and appropriate manner (crossing a double yellow line into the oncoming lane of travel, then striking a tree). These actions (the car accident in conjunction with knowingly failing to properly restrain the child in the car seat) caused the child to sustain bruising, a fractured skull, and swelling of the brain, which ultimately led to her death. Allegations against the father were unsubstantiated as he was not the driver, and had no knowledge the child was improperly restrained in her car seat.

The parents were provided referrals to grief counseling and other appropriate community-based services.

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

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 decision to indicate and close the case was commensurate with case circumstances and evidence gathered throughout the investigation. There were no remaining children in either parents' care and the family had been linked to appropriate community-based providers to meet ongoing needs unrelated to child welfare.

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: 10/28/2024 **Time of Death:** 11:28 PM

Time of fatal incident, if different than time of death: 10:12 AM

County where fatality incident occurred: Ulster
Was 911 or local emergency number called? Yes
Time of Call: 10:12 AM
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	Female	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)

LDSS Response

On 10/28/24, DCDCFS received an SCR report regarding the car accident, and a subsequent report was received on 10/29/24 regarding the child's death because of the accident. DCDCFS initiated their investigation upon receipt of the initial report and attempted to coordinate their efforts with law enforcement, although law enforcement was not always forthcoming. DCDCFS contacted the sources of both reports, completed a CPS history check regarding the family, which revealed no prior child welfare history, and informed the DA of the fatality.

DCDCFS interviewed the parents separately. The mother was interviewed jointly with law enforcement. The mother recalled strapping the child into her car seat. She left the shelter to pick the father up from work and they engaged in an argument when the father got into the vehicle. The mother remembered there was a vehicle in front of them, which she did pass, but could not remember if that occurred before or after the father reportedly grabbed the steering wheel. When the father grabbed the wheel, the mother lost control of the vehicle and hit a tree. The mother believed she was going the speed

limit or “maybe 5 over” at the time of the accident. Neither herself nor the father were wearing seatbelts. The mother had left the bottom strap of the child’s car seat harness undone as she did not want the child to be uncomfortable while sleeping, reporting the child had a rash/eczema. Pediatric records did not indicate the child was being treated for any such skin conditions. Law enforcement had previously interviewed the father and declined a joint interview with DCDCFS. The father reported the mother picked him up from work and they engaged in an argument. The mother began swerving while driving and was taking her hands off the wheel. The father reminded the mother the child was in the backseat. The mother turned into oncoming traffic and the oncoming vehicle moved to avoid hitting them. The father told the mother to stay in her lane, but the mother continued arguing and swerved off the road. The father was not aware of how the child had been strapped into the car seat as he typically would not go near the child until showering after work. The father denied grabbing the wheel. Law enforcement declined sharing photos or eyewitness statements with DCDCFS. Law enforcement did report accident reconstruction showed the vehicle was speeding.

DCDCFS requested the autopsy report; however, it was not yet available. Hospital records were reviewed and indicated the child was found unrestrained in the car seat, face-down. The child presented with a skull fracture and significant brain injury. The child suffered cardiac arrest and multiple rounds of CPR were performed before the child was declared deceased. When asked about the child’s position in the car seat, the hospital physician stated they “cannot say if she was restrained in the car seat or not” but the child was unstable after the accident, sustaining bruising and a parietal occipital skull fracture. Pediatric records were obtained as well, which indicated the child was not up to date on immunizations or well-child visits.

DCDCFS contacted numerous collaterals and completed a comprehensive review of available records pertaining to the accident. Relatives close to the family were spoken with as well. DCDCFS ensured appropriate resources were offered to and provided to the family prior to closing the CPS investigation. At the time of closing, there had been no charges brought against either parent regarding the accident and subsequent death. DCDCFS did find evidence to support the allegations in the report and indicated 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: There is no Child Fatality Review Team in Dutchess County. DCDCFS reviewed the case with their multi-disciplinary team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070072 - Deceased Child, Female, 4 Month(s)	070073 - Mother, Female, 26 Year(s)	DOA / Fatality	Substantiated

070072 - Deceased Child, Female, 4 Month(s)	070073 - Mother, Female, 26 Year(s)	Fractures	Substantiated
070072 - Deceased Child, Female, 4 Month(s)	070073 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Substantiated
070072 - Deceased Child, Female, 4 Month(s)	070073 - Mother, Female, 26 Year(s)	Lacerations / Bruises / Welts	Substantiated
070072 - Deceased Child, Female, 4 Month(s)	070073 - Mother, Female, 26 Year(s)	Swelling / Dislocations / Sprains	Substantiated
070072 - Deceased Child, Female, 4 Month(s)	070074 - Father, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated
070072 - Deceased Child, Female, 4 Month(s)	070074 - Father, Male, 26 Year(s)	Fractures	Unsubstantiated
070072 - Deceased Child, Female, 4 Month(s)	070074 - Father, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated
070072 - Deceased Child, Female, 4 Month(s)	070074 - Father, Male, 26 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
070072 - Deceased Child, Female, 4 Month(s)	070074 - Father, Male, 26 Year(s)	Swelling / Dislocations / Sprains	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? 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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
Burial assistance was provided by the funeral home. The parents were provided bereavement counseling information; it was unknown if the father engaged and the mother's mental health provider did not recommend grief counseling at that time. The family received housing assistance prior to the accident and the mother received such assistance after. The mother was linked to case management services.

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:
Grief counseling information was provided to both parents. The mother had engaged in mental health counseling, though grief-specific services were not yet recommended. It was unknown if the father had engaged prior to the case closing; however, he expressed interest.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ With none of the issues listed noted in case record

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 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