Child Fatality Report

Report Identification Number: SV-25-003

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

Issue Date: May 28, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 7 year(s)
Jurisdiction: Rockland
Gender: Male
Date of Death: 01/18/2025
Initial Date OCFS Notified: 01/21/2025

Presenting Information

An SCR report was received regarding the fatal incident on 01/08/25, which alleged that the 7-year-old male child was walking outside unsupervised and while crossing a busy road was struck by a vehicle. The child sustained blunt force trauma to the head, bleeding from the nose and mouth, and multiple fractures. The mother allowed the child to go outside unsupervised which resulted in him being injured. On 1/18/25 at 12:31PM, the child was pronounced deceased.

Executive Summary

This report concerns the death of a 7-year-old male child. Rockland County Department of Social Services (RCDSS) received an SCR report regarding the child's death on 1/21/25. At the time of the child's death, he resided at home with his mother, father, and 18-, 16-, 15-, 14-, 12-, 11-, 9-, 5-, and 2-year-old surviving siblings. The fatality report was subsequent to an open investigation regarding the fatal incident that was received on 1/8/25.

On 1/8/25 at approximately 4:30PM, the child left the home to go door-to-door in his neighborhood to collect money for his school. The child was approximately 16 minutes walking distance from his residence when he was struck by a vehicle. Police obtained dash camera footage which showed that the child ran between two vehicles and ran out into oncoming traffic and was struck. The child was alone when he was struck by the vehicle. Emergency medical personnel arrived at the scene and the child was transported to the local hospital then airlifted to a second hospital. The child had no blood flow to the brain and was placed on life-support. The child remained on life-support until 1/18/25 at 12:31PM when he succumbed to his injuries.

An autopsy was not performed due to the religious objections of the parents. RCDSS received the death certificate, which stated the cause and manner of death was blunt force trauma. Law enforcement was notified and arrived at the scene of the accident and began an investigation. Law enforcement did not make any arrests, and their investigation closed.

RCDSS made several home visits and interviewed the parents and surviving siblings. All siblings were assessed to be safe in the care of the subject parents.

RCDSS made the appropriate determination to substantiate the allegations of DOA/Fatality, Inadequate Guardianship, Lack of Supervision, Lacerations, Bruises, and Welts, and Internal Injuries against the subject mother and Inadequate Guardianship and Lack of Supervision against the subject father regarding the death of the child. The Investigation Conclusion Narrative stated that the child's death was a direct result of not being properly supervised while in the mother's care. In addition, the subject father was aware that the child had gone out in the past unsupervised.

The mother, father, and surviving siblings declined bereavement services offered by RCDSS. The family stated that they were receiving support from their community.

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

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:
There was detailed documentation of supervisory consult and case planning throughout the investigation.

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: 01/18/2025 **Time of Death:** 12:31 PM

Date of fatal incident, if different than date of death: 01/08/2025
Time of fatal incident, if different than time of death: 05:15 PM

County where fatality incident occurred: Rockland
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? No

Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: walking

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	7 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	43 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)
Deceased Child's Household	Sibling	No Role	Male	16 Year(s)
Deceased Child's Household	Sibling	No Role	Female	14 Year(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Deceased Child's Household	Sibling	No Role	Male	18 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)

LDSS Response

On 1/8/25, RCDSS received an SCR report which said the child was wandering the neighborhood unsupervised in the dark and ran out into the street. The child was struck by a vehicle and was non-responsive. He went into traumatic arrest, suffered bleeding, and required Cardiopulmonary Resuscitation in order to regain a pulse. An additional report was received on 1/21/25 alleging that on 1/18/25 the child had died as a result of his injuries. The investigation into the fatal incident and the investigation into the death ran concurrently. RCDSS initiated their investigation upon receipt of the initial SCR report. The sources of the reports were contacted, the DA was notified of the death, and a CPS history check was completed on the family.

A timeline of the incident was provided by the mother. On 1/8/25, the child returned home from school, ate dinner and at approximately 4:30PM he left the home with his mother’s permission to go door-to-door to collect donations for his school. Around 5:15PM, the mother heard sirens while she was home with six of the surviving siblings. The mother left

the residence to look for the child. As she was walking towards the scene, she was contacted by Hatzoloh, telling her that the child had gotten hurt and was being transported to the hospital. The mother was picked up by a family friend and brought to the emergency room where the child was. The father was at work at the time of the incident and proceeded to the hospital once he was notified. The child remained in the hospital until his death on 1/18/25.

RCDSS made multiple home visits and interviewed the parents and surviving siblings. The mother and father both confirmed that the child was trusted to go door-to-door alone in the neighborhood. This had been allowed for all the children except the 5 and 2-year-old surviving siblings. RCDSS discussed proper supervision with the parents, and the parents agreed that moving forward all the surviving siblings ages 12 and younger will not be unsupervised in the neighborhood.

RCDSS interviewed the verbal children as well as the 18-year-old adult sibling. They all confirmed that their 7-year-old brother was allowed outside in the neighborhood unsupervised to collect money for his school. He had been doing this for the last few weeks. The surviving siblings did not have any additional concerns, and they all appeared free of visible marks or bruises.

RCDSS spoke with the ME, who reported that an external autopsy was conducted on the child and the cause of death was blunt force trauma.

RCDSS contacted numerous collateral sources, including the children's school, the pediatrician, hospital staff, and community members. Services were offered to the family; however, they obtained their own counseling for the surviving siblings. At the close of the investigation, the surviving siblings were deemed as safe, and no criminal charges were brought against either parent. RCDSS found evidence to support the allegations in the report and appropriately substantiated the investigation and closed.

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 Child Fatality Review Team in Rockland County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070008 - Deceased Child, Male, 7 Year(s)	070009 - Mother, Female, 40 Year(s)	Lacerations / Bruises / Welts	Substantiated
070008 - Deceased Child, Male, 7 Year(s)	070009 - Mother, Female, 40 Year(s)	DOA / Fatality	Substantiated

070008 - Deceased Child, Male, 7 Year(s)	070009 - Mother, Female, 40 Year(s)	Fractures	Substantiated
070008 - Deceased Child, Male, 7 Year(s)	070009 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Substantiated
070008 - Deceased Child, Male, 7 Year(s)	070009 - Mother, Female, 40 Year(s)	Internal Injuries	Substantiated
070008 - Deceased Child, Male, 7 Year(s)	070009 - Mother, Female, 40 Year(s)	Lack of Supervision	Substantiated
070008 - Deceased Child, Male, 7 Year(s)	070010 - Father, Male, 43 Year(s)	Inadequate Guardianship	Substantiated
070008 - Deceased Child, Male, 7 Year(s)	070010 - Father, Male, 43 Year(s)	Lack of Supervision	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	☒	☐	☐	☐

Explain:
Risk was assessed throughout the investigation and appropriate services in relation to the death of the SC were offered to the family.

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	☐	☐	☐	☐	☐	☒

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

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 NY 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