Child Fatality Report

Report Identification Number: NY-22-093

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

Issue Date: Apr 19, 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: 3 year(s)
Jurisdiction: Bronx
Gender: Male
Date of Death: 11/26/2022
Initial Date OCFS Notified: 11/26/2022

Presenting Information

An SCR report was received on 11/26/22 regarding the death of two siblings. The report alleged on the same day, at approximately 7:30PM, emergency services were called to the shelter regarding the mother acting erratically. The mother was taken to the hospital. Around 8:00PM, the father arrived at the shelter and found the two children in a bathtub full of water. The children had multiple stab wounds to their necks, chests, and backs, which were caused by the mother. Emergency medical services transported the children to the hospital, where they were pronounced deceased. A second fatality report was made on the same day with the same allegations.

Executive Summary

Two SCR reports were received on 11/26/22, regarding the deaths of two siblings that occurred on the same date. This report concerns the death of the 3-year-old subject child. At the time of their death, the 3-year-old child and his 11-month-old half-sibling, were living in a shelter with their mother and the father of the youngest child. The Administration for Children's Services (ACS) initiated an immediate investigation. ACS learned the father of the youngest child had two additional children, ages 11 and 7, who resided with their mother. ACS conducted a home visit to their residence, and the children were assessed safe in their mother's care.

On 11/26/22, law enforcement responded to the family's shelter unit twice. The initial call was placed by shelter staff, concerning the mother's erratic behaviors. The mother was assessed by law enforcement and was transported to the hospital for further evaluation. The father was not in the unit at the time law enforcement arrived and the mother did not alert law enforcement of the children's presence in the unit; therefore, the children were unaccounted for. Upon learning of the mother's condition, the father returned to the shelter unit to ascertain the children's whereabouts and discovered the children in the bathtub, which was full of water. The father called 911, removed the children from the bathtub, and provided aid until emergency medical services arrived and took over. Both children were transported to the hospital and pronounced dead.

The medical examiner performed an autopsy. The cause of death was multiple sharp injuries of the neck, and the manner of death was homicide. Law enforcement investigated the deaths, and the mother was arrested and charged with murder in the first degree, murder in the second degree, and manslaughter. The criminal investigation remained ongoing at the time this fatality report was written.

ACS completed a home visit to the shelter unit following the fatality. ACS attempted to interview the youngest child's father, as he was the first to discover the children in the bathtub; however, he declined to be interviewed about the fatal event. ACS attempted to interview the mother but was denied access on multiple occasions by law enforcement and hospital staff.

ACS substantiated all allegations against the mother regarding the subject child and his deceased sibling. The father of the 11-month-old child accepted funeral assistance from ACS. The father of the 3-year-old child was incarcerated and efforts to contact him through the prison were unsuccessful at the time the CPS investigation was closed.

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

Explain:
There were no surviving children in the subject child's household, therefore, the determination Safety Assessment was not required. The children of the deceased sibling's father were assessed and they remained in the care of their mother.

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:
ACS was unable to interview the mother due to the ongoing criminal case. Information on bereavement services were provided and the case was closed.

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: 11/26/2022 **Time of Death:** 08:48 PM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 07:57 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: 2
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	11 Month(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Year(s)
Deceased Child's Household	Father	No Role	Male	31 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)

LDSS Response

ACS immediately initiated their investigation, coordinated with LE and the DA's office, and reviewed CPS history. There were no surviving children in the household. The father of the 3-year-old subject child was incarcerated at the time of the fatality and efforts to interview him were unsuccessful. ACS made multiple attempts to interview the father of the 11-month-old deceased sibling; however, he declined to be interviewed about the fatal incident. The half-siblings of the 11-month-old deceased sibling resided in a different household and were assessed safe in their mother's care on 11/29/22. The children were interviewed, and no concerns were reported regarding the deceased children's household.

ACS learned LE responded to the case address twice on the evening of 11/26/22. An initial 911 call was received at 7:21PM regarding the mother behaving irrationally, in that she was naked and burning something on the stove. LE was removing the mother from the shelter unit and when asked, the mother stated she did not know if there were children in the home. The children were not accounted for at this time and the mother was taken by ambulance to the hospital. At 7:57PM, a second 911 call was placed by the 11-month-old's father. The father had not been staying at the shelter as the mother kicked him out the day prior to the fatality; however, he was made aware the mother was being taken to the hospital. He returned to the shelter and entered the family's unit to find the children in the bathtub full of water. The father removed the children from the bathtub and placed the 3-year-old child on the bed and the 11-month-old on the floor and attempted to cover their wounds with his hands and items from the floor. The children were transported by ambulance to the hospital, where the 3-year-old was pronounced dead at 8:48PM and the 11-month-old was pronounced dead at 8:59PM.

ACS spoke with hospital staff, and both children presented in cardiac arrest, with stabbing injuries and blood loss. Signs of trauma were observed such as multiple puncture wounds to the neck of the 3-year-old and the 11-month-old had multiple stab wounds to his neck, chest, and back. It was suspected that the object used was kitchen shears, as they were observed on the bathroom floor. Lifesaving efforts were performed; however, cardiac monitors measured no activity greater than 60 seconds and the children presented in rigor mortis.

ACS maintained collateral contact with the DA's office throughout the investigation. Despite consent from the DA, ACS was not permitted contact with the mother. LE did not share the mother's statement with ACS and the record did not reflect ACS requested the father's statement. ACS learned the mother was arrested 11/27/22 and had been admitted to a psychiatric hospital following the fatalities.

ACS interviewed shelter staff and learned the family had resided in the shelter since 2021. On 11/26/22, shelter staff observed a leak coming from the family's unit and staff observed the mother burning things in the oven and trying to flood the unit. Shelter staff made the initial 911 call. Staff confirmed the father was not in the unit at that time. A recent change in the mother's behavior was noted by shelter residents and coincided with the mother practicing the chakra methodology. ACS learned from staff the mother underwent a psychological evaluation on 10/27/22; however, it was not documented what event precipitated this. Shelter staff reported a diagnosis of major depression with no follow-up treatment.

In response to the fatality, ACS substantiated the allegations against the mother and closed the investigation. A legal consultation was held, and it was determined there was not enough to file a petition against the father of the 11-month-old, as there was nothing to suggest the father knew or should have known that the mother was undergoing mental health concerns that posed a risk to the children.

Official Manner and Cause of Death

Official Manner: Homicide
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: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
062481 - Deceased Child, Male, 3 Yrs	062682 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
062481 - Deceased Child, Male, 3 Yrs	062682 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
062481 - Deceased Child, Male, 3 Yrs	062682 - Mother, Female, 22 Year(s)	Internal Injuries	Substantiated
062481 - Deceased Child, Male, 3 Yrs	062682 - Mother, Female, 22 Year(s)	Lacerations / Bruises / Welts	Substantiated
062681 - Deceased Child, Male, 11 Month(s)	062682 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
062681 - Deceased Child, Male, 11 Month(s)	062682 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
062681 - Deceased Child, Male, 11 Month(s)	062682 - Mother, Female, 22 Year(s)	Internal Injuries	Substantiated

062681 - Deceased Child, Male, 11 Month(s)	062682 - Mother, Female, 22 Year(s)	Lacerations / Bruises / Welts	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:

ACS was not granted access to the mother. The father to the 3yo subject child was incarcerated at the time and an interview was not documented. The father to the deceased sibling refused to participate in an interview regarding the fatal event.

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: Murder **Degree:** 1

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
11/27/2022	Subject Mother	Pending	Arrest
Comments:	The mother was arrested and charged with murder in the first degree on 11/27/22. The mother was also arraigned on charges of murder in the second degree and manslaughter. The mother remained incarcerated at the time the CPS investigation was closed and criminal proceedings were ongoing at the time this fatality report was written.		

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:
The subject child had no surviving siblings.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother received psychiatric services immediately following the fatality. Supportive services were repeatedly offered to the deceased sibling's father; however, he 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?	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

In 2019, ACS substantiated allegations of Inadequate Guardianship and Parent Drug Alcohol Misuse against the mother, regarding the now 3-year-old deceased child. A CPS services case was opened following the investigation.

Known CPS History Outside of NYS

ACS reached out to New Jersey, Pennsylvania, and Florida as the family was assumed to have resided in those states. There was no known CPS history outside of NYS for the deceased children.

Preventive Services History

The mother and oldest child, then age 4 months, were involved in a services case, which opened 12/4/19. The documented services requested were Drug Counseling/Treatment and Early Intervention. The case record indicated the family would benefit from case management and PPRS. At the time the case was open, the child's father was incarcerated. It was learned the mother and child left the New York City area around November 2019 and ACS was unsuccessful in its attempts to locate the family throughout the open case. The mother was uncooperative with ACS and would not provide her location or the child's location. A legal consult was held, and ACS made attempts to ascertain the family's location through other state agencies where the family was believed to be staying and attempted visits to any last known addresses obtained from collateral contacts. The agency responsible for case planning was ACS. The case was closed on 4/9/20 as the family was unable to be located.

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