Child Fatality Report

Report Identification Number: BU-24-021

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

Issue Date: Apr 01, 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: 9 year(s)
Jurisdiction: Niagara
Gender: Male
Date of Death: 10/28/2024
Initial Date OCFS Notified: 11/01/2024

Presenting Information

An SCR report alleged on 10/28/24 at approximately 9:00 PM, the mother jumped into a group of waterfalls with the 9-year-old subject child and the 5-month-old sibling. As a result, the mother and children were presumed to be dead.

Executive Summary

This fatality report concerns the death of the 9-year-old subject child that occurred on 10/28/24. A report was made to the SCR on 11/01/24 alleging the mother, subject child and 5-month-old sibling presumably died after the mother forced them into a waterfall. There were surviving siblings, children of the father, aged 15, 15, 5 and 1 year, who resided outside of the home. They were assessed as safe with their parents.

Niagara County Department of Social Services (NCDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. Law enforcement noted the case was considered a missing person report as the bodies had not been recovered. It remained unknown if the bodies were located.

NCDSS contacted the child's father, who was also the father of the surviving siblings. The siblings did not have a relationship with the mother and had minimal contact with the subject child. The father nor the siblings had information regarding the death. It remained unknown who the now deceased sibling's father was.

NCDSS made appropriate collateral contacts and appropriately determined the allegations. The allegations of Inadequate Guardianship and DOA/Fatality were substantiated against the mother. The Investigation Conclusion Narrative stated there was a fair preponderance of evidence that the mother’s actions showed there was a direct effect on the safety of the children as the mother forced the children over the waterfall prior to jumping in herself, resulting in their deaths.

NCDSS appropriately offered bereavement services to the family. The Safety Assessments and required reports were completed timely and with accuracy. Casework activity met regulatory requirements, and the investigation was closed timely on 12/24/24.

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:
The decision to close the case was appropriate.

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 met regulatory requirements.

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:** Unknown

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

County where fatality incident occurred: Niagara
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Unknown
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: 2

Adults: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Month(s)
Other Household 1	Father	No Role	Male	47 Year(s)

LDSS Response

On 11/01/24, NCDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, NCDSS contacted the source of the report, coordinated investigative efforts with law enforcement and attempted to assess the safety of the surviving siblings. The medical examiner and district attorney's offices were contacted.

NCDSS gathered information from law enforcement. Law enforcement reported that the case was considered a missing person report as the bodies had yet to be recovered. The father of the subject child reported to law enforcement that he last had contact with the child in August 2024. A surveillance video showed the mother walking toward the waterfalls with the child and a stroller around 8:53 PM on 10/28/24. There were 2 witnesses who called 911, reporting the mother went over the safety rail with the subject child, then climbed back over and took the now deceased sibling out of the stroller. The mother then went into the water with the children.

On 11/04/24, the siblings were assessed to be safe, except for the 1-year-old sibling. The 15-year-old siblings reported seeing the child once every 3 years, and that it was believed the mother had a mental health condition. It was noted the mother kept the child from the father.

The father was interviewed via phone and reported he had not seen the child since August 2024 and that he did not have contact with the mother except for when he attempted to see the child. The father declined further engagement with NCDSS and did not allow the caseworker to observe the 1-year-old sibling.

NCDSS conferenced with their legal department, and it was determined it was not necessary to obtain an access order regarding the youngest surviving sibling as there was no evidence that the sibling was in danger.

The investigation was appropriately determined and closed.

Official Manner and Cause of Death

Official Manner: Unknown

Primary Cause of Death: Unknown

Person Declaring Official Manner and Cause of Death: Unknown

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: The death was referred to an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069972 - Deceased Child, Male, 9 Year(s)	069974 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
069972 - Deceased Child, Male, 9 Year(s)	069974 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
069973 - Sibling, Female, 5 Month(s)	069974 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
069973 - Sibling, Female, 5 Month(s)	069974 - Mother, Female, 33 Year(s)	Inadequate Guardianship	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: The 15-year-old siblings were referred to their school's counselor.				

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?	☐	☒	☐	☐

Explain as necessary:
The siblings did not need to be removed and were deemed safe with their parents.

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:
The siblings were offered bereavement counseling in response to the death. The two eldest siblings were connected with their school's counselor.

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:
The father declined bereavement services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/13/2023	Sibling, Female, 13 Years	Other Adult - OA2 (mother of SS1), Female, 39 Years	Inadequate Guardianship	Substantiated	No
	Sibling, Female, 13 Years	Other Adult - OA2 (mother of SS1), Female, 39 Years	Lacerations / Bruises / Welts	Substantiated	

Report Summary:
An SCR report alleged on 07/11/23, the mother of the then 13-year-old sibling slapped that sibling. That mother threw a chair at the sibling and as a result, the sibling sustained a bruise on her left arm that was dark purple.

Report Determination: Indicated | **Date of Determination:** 11/09/2023

Basis for Determination:
The allegations were substantiated. The Investigation Conclusion Narrative noted the sibling stated her mother hit her several times and showed a linear bruise. The sibling stated the mother poked her with her finger. That mother denied throwing a chair but stated she did slap the sibling yet did not cause a bruise. That mother reported this was an isolated incident.

OCFS Review Results:
The investigation was initiated timely, and a CPS history check was documented. The source was contacted. A home visit was made, and the family was interviewed. Appropriate collateral contacts were made. The 7-day Safety Assessment was completed timely. Concerns that arose during the investigation were adequately explored.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

02/23/17-04/24/17 The SM and BF were unsubstantiated for IG, XCP and L/B/W of the SC.

04/24/18-08/17/18 The mother of a now 15-year-old sibling was unsubstantiated for XCP and L/B/W and substantiated for IG regarding her child.

11/27/18-03/05/19 The BF was unsubstantiated for IG of the SC.

02/18/20-04/27/20 The BF was unsubstantiated for IG and XOTH of the SC.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

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