Child Fatality Report

Report Identification Number: NY-19-069

Prepared by: New York City Regional Office

Issue Date: Dec 11, 2019

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 has an open 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		
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	
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: 10 year(s)
Jurisdiction: New York
Gender: Female
Date of Death: 06/15/2019
Initial Date OCFS Notified: 06/15/2019

Presenting Information

The SCR registered two reports on 6/15/19, alleging that at 2:20 P.M., the 10-year-old SC was pronounced dead by EMS due to a possible strangulation. The report stated the SC was found by her three older siblings unresponsive in her bed surrounded by blankets. The SC's body had bruising around her neck and all over her body, as well as popped blood vessels in her eyes. The report also stated one sibling had last seen the SC alive on the evening of 6/14/19. The report also stated the SC was last in the care of the mother and the parent substitute (PS). The second report stated the SC was killed by the PS who also murdered the mother and then committed suicide.

Executive Summary

The SC was 10 years old (yo) when she died on 6/15/19. The ME reported the SC's cause of death was manual strangulation and the manner of death was homicide.

The SC resided with her mother, the PS and her three siblings ages: 7, 13, and 15 yo. The SC's and the 13 yo sibling's father had no contact with them and the mother had obtained full custody of these children. The father of the 7 yo sibling was incarcerated and had no contact with this child. The father of the 15 yo sibling resided in Albany and had regular contact with his child.

On 6/15/19, the SCR registered two reports regarding the death of the SC. The allegations of the reports were DOA/FATL, C/T/S, L/B/W, II, and IG of the SC by the mother and the PS, and IG of the siblings by the PS.

According to ACS' investigation, on 6/15/19 the 15 yo discovered the mother, PS and the SC unresponsive and called their MA and 911. Once EMS and the NYPD responded to the home, it was learned that the mother and the SC were dead, and the PS was unconscious. It was later learned the PS murdered the mother and the SC, and then attempted to take his own life. The PS was placed under police custody while on life support and subsequently died on 6/30/19.

ACS initiated and completed a timely investigation and responded appropriately to the traumatic circumstances of the SC's death. The MA responded to the home immediately and assumed the responsibility of the surviving siblings. The three siblings were medically cleared at Jacobi Hospital and were free of marks and bruises. They were subsequently interviewed at the Child Advocacy Center (CAC) and referred for therapeutic services.

On 6/18/19, ACS held a Child Safety Conference (CSC) and determined it was in the siblings' best interest to remain in the care of their MA. The MA filed for custody of the children and was granted temporary guardianship.

On 8/21/19, ACS substantiated the allegations of DOA/FATL, II, L/B/W, C/T/S and IG against the PS based on the ME's report which determined the SC was strangled. The allegation of IG of the siblings by the PS was substantiated. ACS cited the domestic violence the PS perpetrated against the mother in the presence of all the children.

ACS unsubstantiated all the allegations against the mother as there was no credible evidence to substantiate any of the allegations.

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?** No

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:
N/A

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate 24 Hour Assessment
Summary:	ACS selected a safety decision that was not consistent with the case circumstances.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The safety decision selected was not consistent with the case circumstances.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Adequacy of Risk Assessment Profile (RAP)

Summary:	ACS listed the MA as the caretaker as oppose to the subjects of the report. In addition, some of the responses to the questions listed in the RAP applied to the MA and others to the subjects of the report.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/15/2019 **Time of Death:** 02:20 PM

County where fatality incident occurred: Bronx
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 alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? Unable to determine

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	10 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	15 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	7 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	13 Year(s)

LDSS Response

Upon receipt of the report, ACS initiated the investigation by contacting the NYPD, medical staff and interviewing the family.

According to the account provided by the 7 yo, on 6/14/9 she and the SC stayed home because their school was closed. The 7 yo said she heard the mother and the PS arguing in their bedroom and then saw the mother run out of the room and enter the 13 yo sibling's room. The 7 yo stated that at about 5:30 P.M, she saw the PS carry the SC to her bed. The 7 yo did not provide specific details or a time line of the reported events. The 13 yo reported on 6/14/19, he attended school and returned home at about 6:30 P.M. The 13 yo said he knocked on the mother's bedroom door and the PS told him the mother was asleep. The 13 yo stated the SC was also asleep. The 13 yo said the PS appeared fine and sent him to the store to get cold cuts to make sandwiches.
According to the 15 yo, on 6/14/19 she went to school; and after she attended her friend's musical. The 15 yo said once the musical was over, she texted the mother to let her know she was on her way home, but the mother did not respond. The 15 yo said she arrived at the home at about 9:00 P.M. and knocked on her mother's bedroom door; however, the PS told her there were sandwiches in the microwave. The 15 yo said the 13 yo was playing videos, the 7 yo was watching TV, and the SC was asleep in her room.

The older sibling reported that on 6/15/19, they were all awake except for the SC who was asleep. The 13 yo stated this was unusual. The 13 yo said he went to the SC's room and found the SC unresponsive, he stated her body was cold. The 13 yo stated their MA called to speak to his mother, but she did not respond. Therefore, he opened the door of the mother's bedroom and saw blood on the floor and alerted the 15 yo who in turn informed the MA who had remained on the line. Both the 13 yo and the 15 yo said the MA instructed them to leave the home and then she called 911.

On 6/15/19, the 15 yo said she got up and noticed the SC who usually got up early was asleep. The 15 yo said she went to the room to check the SC at about 11:00 A.M. and found her dead. The 15 yo stated she banged on the mother's room and got no response, which was unusual. She said the mother's door was blocked, and once she she pushed through, she saw the PS slumped over with blood spats on the floor next to her mother's body. The 15 yo described the PS as "petty" and added that he was verbally and physically abusive to the mother. When asked, the 15 yo stated her mother never called the NYPD against the PS.

The MA said the mother had asked her for a loan to buy clothes for the children and she called the home to arrange to meet up with her but got no answer. The MA said she was able to reach the children and that was when she learned of the incident. ACS arranged to assess the MA's home as she stated the children were staying in her care. ACS assessed the home to be safe and completed clearances for the aunt and adult son.
The MA said on 6/15/19 she was supposed to meet up with the mother, but she was unable to reach by phone. The MA said she was able to contact the children and when they went to get the mother, they discover she was dead, and she told them to leave the home and then called 911. The MA informed ACS that the children were going to stay with her, and ACS assessed her home to be safe and completed clearances for the MA and the adult son.

According to EMS, the SC was found on her bed face down with a sheet and blanket around her; when she was placed on the floor, they found rigor had set. The mother was found in her room, lying on the bed covered with a blanket. The PS was also in the room lying faced up on the bed with his eyes open and in and out of consciousness. Once EMS removed the blanket, the found a gun lying next to them.

ACS indicated the report against the PS.

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)?No

Comments: There was no documentation of a MDT investigation; however, the investigation adhered to previously approved protocols for joint investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

Comments: There is no OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
050447 - Deceased Child, Female, 10 Yrs	050448 - Mother, Female, 34 Year(s)	Internal Injuries	Unsubstantiated
050447 - Deceased Child, Female, 10 Yrs	050448 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
050447 - Deceased Child, Female, 10 Yrs	050448 - Mother, Female, 34 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
050447 - Deceased Child, Female, 10 Yrs	050449 - Mother's Partner, Male, 32 Year(s)	Internal Injuries	Substantiated
050447 - Deceased Child, Female, 10 Yrs	050449 - Mother's Partner, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
050447 - Deceased Child, Female, 10 Yrs	050448 - Mother, Female, 34 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
050447 - Deceased Child, Female, 10 Yrs	050449 - Mother's Partner, Male, 32 Year(s)	Lacerations / Bruises / Welts	Substantiated
050447 - Deceased Child, Female, 10 Yrs	050449 - Mother's Partner, Male, 32 Year(s)	Choking / Twisting / Shaking	Substantiated
050447 - Deceased Child, Female, 10 Yrs	050449 - Mother's Partner, Male, 32 Year(s)	DOA / Fatality	Substantiated
050447 - Deceased Child, Female, 10 Yrs	050448 - Mother, Female, 34 Year(s)	DOA / Fatality	Unsubstantiated
050450 - Sibling, Female, 15 Year(s)	050449 - Mother's Partner, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
050451 - Sibling, Male, 13 Year(s)	050449 - Mother's Partner, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
050452 - Sibling, Female, 7 Year(s)	050449 - Mother's Partner, Male, 32 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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
N/A

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: # 3- The risk factors involving the siblings were properly assessed, but the RAP was not completed properly.				

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

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? Yes
Explain:
The MA immediately took over the responsibility of the surviving siblings' care and filed for custody.The siblings were medically cleared and referred for therapy in response to the fatality.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was murdered by the PS and the MA immediately filed for the custody of the siblings.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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

The PS was listed as a subject of a report dated 4/29/11 that involved his biological child with the allegation of SA. The report was unfounded.

The mother was listed in a SCR report dated 4/23/07 with no role. The report listed the father of the SC for IG of the siblings, and it was indicated.

On 5/17/12, the mother was listed as a subject of an SCR report dated 5/17/12 involving the now 13-year-old sibling for allegations of XCP, L/B/W/ and IG, and was indicated.

Known CPS History Outside of NYS

The family had no known CPS history outside 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