Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-084

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

Issue Date: Feb 22, 2024

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: 0 day(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 09/01/2023
Initial Date OCFS Notified: 09/01/2023

Presenting Information

On 9/1/2023, the New York City Administration for Children's Services (ACS) received an SCR report concerning the death of the newborn subject child which occurred that day. The report alleged the mother gave birth to the subject child sometime prior to 7:00 AM and then wrapped the child in a sweatshirt and placed her in a plastic grocery bag. The mother brought the bag containing the subject child to the home of the maternal grandmother and left the home. The grandmother discovered the subject child unresponsive in the bag and immediately contacted 911. Emergency medical services responded to the home, began life saving efforts, and transported the subject child to the hospital where she was pronounced deceased. A subsequent SCR report was received on the same date and alleged the mother gave birth to a twin sibling. The report alleged the mother was homeless, had no supplies, was mentally unstable, and was unable to care for the sibling.

Executive Summary

This report concerns the death of a newborn subject child which occurred on 9/1/2023. The mother was homeless and gave birth to the subject child at the home of an acquaintance. At the time of the subject child's birth, the mother had no other children in her care; however, the mother was pregnant with twins and a surviving twin sibling was born in the hours after the subject child's death. The sibling was removed from the mother, remained hospitalized for 6 weeks, and was released to the care of the maternal grandmother. There were 10 and 11-year-old surviving half-siblings who resided with their father and had no contact with the mother since 2018.

Around 3:00 AM on 9/1/2023, the mother went to the home of an acquaintance and gave birth to the subject child in the bathroom. The acquaintance observed the subject child crying and contacted 911 out of concern for the child's safety. Prior to the arrival of emergency services, the mother left the home with a small bag. Around 6:30 AM, the mother went to the home of the maternal grandmother. The mother handed the bag to the grandmother and told her to be careful when she opened it, the mother then left the home. The grandmother opened the bag and found the subject child inside and unresponsive. The grandmother immediately contacted 911 and emergency medical services responded to the home, initiated resuscitative measures, and transported the subject child to the hospital where she was pronounced deceased.

Law enforcement conducted a search of the area to locate the mother and she was found on the street. The mother was transported to the hospital where it was determined she had been pregnant with twins. The surviving twin sibling was delivered via cesarean section. At the time of the birth, the sibling and the mother tested positive for cocaine. The sibling was born premature, weighing 3 pounds and 7 ounces, and required medical assistance due to respiratory issues. The mother was hospitalized at an inpatient psychiatric facility and declined to speak with ACS.

An autopsy was completed; however, the final autopsy report and death certificate were not available at the time the CPS investigation was closed. ACS requested preliminary information from the office of the medical examiner; however, no such information was provided. The law enforcement investigation remained ongoing; however, there were no charges or arrests related to the fatality at the time the CPS investigation was closed.

The allegation of Inadequate Guardianship was substantiated against the mother regarding the subject child. The Investigation Conclusion Narrative noted a pattern of the mother's history of giving birth to children with a positive toxicology for cocaine and failing to provide for the children's needs. The allegation of DOA / Fatality was unsubstantiated as ACS was unable to gather information from the hospital or medical examiner regarding the cause and

manner of death.

The allegations of Inadequate Guardianship and Parent's Drug / Alcohol Misuse were substantiated against the mother regarding the surviving twin sibling. The Investigation Conclusion Narrative noted the sibling and mother tested positive for cocaine at the time of the child's birth. The sibling required medical assistance due to his prematurity and inability to breathe on his own.

The case was indicated and opened. A neglect petition was filed against the mother in family court and the surviving twin sibling was removed from her care and placed with the maternal grandmother. The record did not reflect the grandmother was educated regarding safe sleep practices during the CPS investigation; however, the contract foster care agency verified safe sleep was discussed with the grandmother.

Bereavement services and burial assistance were offered to the grandmother. The mother declined all interaction with ACS and, as such, services could not be offered or provided to her.

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? N/A

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 gathered information from pertinent sources throughout the investigation and the allegations were determined in congruence with the information gathered. Safety was adequately assessed throughout the investigation. A subsequent SCR report was received on 2/1/2024 after the mother was charged with homicide. A new investigation was initiated and remained open as of the writing of this report.

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: 09/01/2023 **Time of Death:** 07:32 AM

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: 07:10 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	0 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	31 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	0 Day(s)

LDSS Response

Immediately upon receipt of the SCR report, ACS coordinated with law enforcement, conducted a search of CPS history, and assessed the surviving twin sibling to be safe at the hospital.

ACS attempted to interview the mother on multiple occasions; however, the mother declined all attempts at contact. Furthermore, the mother would not sign releases or give permission for ACS to gather medical records regarding the subject child.

ACS interviewed the maternal grandmother who reported she was aware the mother was pregnant. The grandmother stated the mother was having labor pains on 8/31/2023 and she brought the mother to the hospital; however, the mother left as

she believed the hospital would force her to undergo a psychological evaluation. The grandmother was unaware of where the mother went after leaving the hospital and contacted 911 immediately upon the mother returning to her home with the subject child in a bag.

ACS questioned the grandmother, the father of the surviving 10 and 11-year-old siblings and obtained a copy of the surviving newborn twin sibling's birth certificate; however, they were unable to ascertain the identity of the biological father of the deceased child and newborn twin sibling.

ACS observed the surviving 10 and 11-year-old siblings and assessed them to be safe in the care of their father. The father of the 10 and 11-year-old sibling reported he had full custody of the children, and they had no contact with their mother.

On 1/30/2024, the mother was arrested and charged with Manslaughter in the 2nd degree and Criminally Negligent Homicide. The initial CPS fatality investigation was closed on 10/31/2023; however, on 2/1/2024, a subsequent SCR report was registered regarding the fatality and ACS initiated a new investigation into the death of the subject child. ACS spoke with the district attorney's office and learned the mother was arrested on 1/30/2024 and remained incarcerated. ACS learned from the office of the medical examiner that the final autopsy report and death certificate were complete and listed the manner of death as "Homicide" and the cause of death as "Asphyxia due to Smothering." ACS visited the home of the grandmother and assessed the surviving twin sibling to be safe in her care. The 2/1/2024 CPS investigation remained open as of the writing of this report and, as such, the allegations and determination thereof listed in this report reflect only the initial CPS investigation which was open from 9/1/2023 to 10/31/2023.

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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066221 - Deceased Child, Female, 0 Day(s)	066223 - Mother, Female, 31 Year(s)	DOA / Fatality	Unsubstantiated
066221 - Deceased Child, Female, 0 Day(s)	066223 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
066222 - Sibling, Male, 0 Day(s)	066223 - Mother, Female, 31 Year(s)	Inadequate Guardianship	Substantiated
066222 - Sibling, Male, 0 Day(s)	066223 - Mother, Female, 31 Year(s)	Parents Drug / Alcohol Misuse	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?	☒	☐	☐	☐

Additional information:
The mother declined to cooperate with ACS and thus could not be interviewed.

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 mother would not speak with or cooperate with ACS; therefore, her needs could not be adequately assessed.
An appropriate assessment of risk was conducted and services were offered in accordance with the identified risk factors.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The surviving twin sibling was removed from the mother and placed with the maternal grandmother through a foster care agency.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?
☒Family Court ☒Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/06/2023	There was not a fact finding	Article 10 Remand
Respondent:	066223 Mother Female 31 Year(s)	
Comments:	A neglect petition was filed against the mother regarding the newborn surviving twin sibling regarding his positive toxicology for cocaine at the time of his birth.	

Criminal Charge: Manslaughter **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**

01/30/2024	The mother	01/30/2024	Incarcerated, criminal court ongoing
Comments:	The mother was arrested on 1/30/2024 and charged with Manslaughter in the 2nd degree and Criminally Negligent Homicide.		

Have any Orders of Protection been issued? Yes	
From: 09/06/2023	**To:** Unknown
Explain: An order of protection was put in place against the mother regarding the surviving newborn twin sibling.	

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
Family planning services, mental health services, and alcohol / substance abuse services could not be discussed with or offered to the mother as she declined to cooperate or communicate with ACS.

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 surviving twin sibling was placed in foster care with the maternal grandmother through an agency and has been referred to early intervention services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services and burial assistance were offered to the maternal grandmother; however, it was unknown if those services were utilized. Services could not be offered to the mother as she declined all ACS contact.

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

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

The mother was the subject of one indicated CPS investigation in October of 2016. The mother admitted she was under the influence of illegal substances while the sole caretaker of the now 10-year-old surviving sibling and also admitted she placed a plastic bag over the sibling's head. The mother had a history of mental illness and substance misuse issues and was not engaged with treatment. The allegations of Inadequate Guardianship and Parent's Drug / Alcohol Misuse were substantiated against the mother regarding the now 10-year-old surviving sibling.

The mother was the subject of an unfounded CPS investigation in May of 2016. The SCR report alleged the mother had physically assaulted the father of the now 10 and 11-year-old surviving siblings in the presence of the siblings; however, there was not enough credible evidence and the allegation of Inadequate Guardianship was unsubstantiated.

A 2019 CPS investigation was unfounded for the allegation of Inadequate Guardianship against the father of the now 10 and 11-year-old surviving siblings, the maternal grandmother, and the paternal grandfather regarding the surviving siblings. The report alleged the adults were physically abusive towards the children; however, there was a lack of credible evidence to support the allegations.

Known CPS History Outside of NYS

There was no known history outside of NYS.

Preventive Services History

On 11/14/2016, a court-ordered Preventive Services Case opened pursuant to the October 2016 SCR report. The now 10 and 11-year-old surviving siblings were remanded to the care of their father and the mother was court-ordered to comply with mental health and substance abuse services. An order of protection was put in place barring the mother from unsupervised contact with the children. The mother did not engage with services and the order of supervision expired on 4/30/2018. On 6/12/2018, the father was granted sole legal and physical custody of the children.

Foster Care Placement History

Two children unrelated to this report were removed from the mother and placed in foster care in 2022 due to the mother's mental health substance misuse issues. The children were subsequently freed for adoption.

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