Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-23-125

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

Issue Date: May 28, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 5 year(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 12/18/2023
Initial Date OCFS Notified: 12/18/2023

Presenting Information

The New York City Administration for Children's Services (ACS) received an SCR report on 12/18/2023, which alleged on the same date the mother (SM) contacted 911 at approximately 11:21 AM and stated the 5-year-old subject child (SC) and twin 5-year-old deceased sibling (DS) were found unresponsive in the living room after she exited the shower. Paramedics arrived and both children were pronounced dead at 11:30 AM. The children were each found to be in full rigor mortis. The time of the children's death was not consistent with the mother's explanation of events. The father (BF) was at work at the time of the fatal incident and had an unknown role. A subsequent SCR report was received on the same date and additionally alleged the condition of the home was deplorable and a hazard to the health of the children.

Executive Summary

This report concerns the death of a 5-year-old child which occurred while in the care of her mother. ACS received the SCR report and coordinated their response with law enforcement. Law enforcement initially informed ACS the mother made discrepancies in her statements regarding the timeline of the fatal incident and their investigation was proceeding as a homicide investigation. The children were found by emergency responders in full rigor mortis, conflicting with the mother's account of the children being alive 10 minutes prior to her discovering them unresponsive. Law enforcement asked ACS not to interview the mother as she had been brought to the hospital for an evaluation and they had not fully interviewed her for their investigation.

ACS interviewed the father. The father stated the children had displayed signs of minor illness before he left town for work on 12/16/2023. The father stated he spoke with the mother on 12/17/2023, and she informed him she was going to take the children to the doctor to be checked out on 12/18/2023. The father stated he came home from work early to assist the mother with taking the children to the doctor and arrived home when the ambulances and law enforcement were at the home. The father had no previous concerns for the children in the care of the mother.

ACS interviewed the medical examiner following the autopsies. The child had foam coming from her mouth which was consistent with drowning, congestive heart failure, or an overdose. The deceased sibling sustained damage to his frenula, consistent with trauma. The medical examiner stated the deaths were suspicious in nature. The final autopsy report was not available at the time the investigation was closed.

The mother remained hospitalized for the duration of the investigation. The allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the deaths of the subject child and twin sibling were substantiated. The allegations against the father regarding the deaths of the children were unsubstantiated and the investigation was closed on 2/16/2024. In March 2024, the medical examiner declared the manner of death to be homicide. The criminal investigation was ongoing at the time this report was written.

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

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 in the case record of supervisory consult and the decision to close the case was made commensurate with the case circumstances.

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: 12/18/2023 **Time of Death:** Unknown

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: 11:00 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: 2

Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	61 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	5 Year(s)

LDSS Response

Within the first 24 hours of the investigation, ACS contacted the source of the report, notified the ME and DA's offices of the death, documented a CPS history check, and interviewed medical collaterals. ACS was informed by LE the SM stated the SC and DS each displayed signs of a minor illness in the days prior to finding them dead. LE stated the SM informed the 911 operator she found the children unresponsive in their bedroom and was instructed by the operator to bring them to the living room where they were when EMS arrived. LE stated the SM gave several discrepancies in her explanation of events and the investigation was being conducted as a homicide investigation. LE informed ACS the SM was brought to the hospital for a psychiatric evaluation and asked ACS not to interview or contact the SM until LE had an opportunity to interview her further.

ACS interviewed the BF in a relative's home. The BF stated he left town for work in the evening of 12/16/2023. The BF stated he usually worked out of town Saturday evenings through Wednesday evenings and the children were left in the care of the SM. The BF stated both children displayed signs of a minor illness in the days before he left for work. The BF stated he and the SM gave the children over the counter medications and they returned to normal behavior. The BF stated he spoke with the SM on 12/17/2023, and she stated the children were still displaying signs of illness and she was going to take them to the doctor. The BF stated he returned home early from work on 12/18/2023 to assist the SM with taking the children to the doctor and arrived home to LE and the ambulances outside. The BF stated he had no previous concerns for the children in the care of the SM. Referrals for services in response to the deaths of the children were made on behalf of the BF.

ACS interviewed school staff regarding the SC and DS. There were no concerns identified for the SC or the DS in the care of the SM and BF. The SC was last in school on 12/15/2023 and it was noted she had some nasal congestion though finished the school day. The DS was sent home sick from school on 12/12/2023, though returned to school the following day and was present on 12/15/2023, the last day of school prior to his death.

ACS interviewed the ME. The ME stated the deaths of the SC and DS were suspicious in nature. The SC had foam coming from her mouth, consistent with drowning, an overdose, or congestive heart failure. The DS sustained damage to his frenula which was consistent with trauma to the face. The ME did not provide ACS with a cause or manner of death and stated further testing was pending. The final autopsy report was pending at the time the investigation closed.

ACS interviewed LE investigating the deaths of the SC and DS. LE did not provide much information to ACS other than to state the investigation was ongoing and asked ACS to not contact the SM until they gave them clearance to do so.

The allegations against the SM regarding the deaths of the SC and DS were substantiated. The allegations against the father regarding the deaths of the SC and DS were unsubstantiated. The allegations against the SM and BF regarding the condition of the home were unsubstantiated and the investigation was closed on 2/16/2024. The SM remained hospitalized

for the duration of the investigation. In March 2024, the ME declared the manner of death for the SC and DS to be homicide and the criminal investigation remained open.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: Pending
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: ACS does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066944 - Deceased Child, Female, 5 Year(s)	066946 - Mother, Female, 41 Year(s)	DOA / Fatality	Substantiated
066944 - Deceased Child, Female, 5 Year(s)	066946 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Substantiated
066944 - Deceased Child, Female, 5 Year(s)	066946 - Mother, Female, 41 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066944 - Deceased Child, Female, 5 Year(s)	066947 - Father, Male, 61 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066944 - Deceased Child, Female, 5 Year(s)	066947 - Father, Male, 61 Year(s)	Inadequate Guardianship	Unsubstantiated
066945 - Sibling, Male, 5 Year(s)	066946 - Mother, Female, 41 Year(s)	DOA / Fatality	Substantiated
066945 - Sibling, Male, 5 Year(s)	066946 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Substantiated
066945 - Sibling, Male, 5 Year(s)	066946 - Mother, Female, 41 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066945 - Sibling, Male, 5 Year(s)	066947 - Father, Male, 61 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
066945 - Sibling, Male, 5 Year(s)	066947 - Father, Male, 61 Year(s)	Inadequate Guardianship	Unsubstantiated

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?	☐	☒	☐	☐

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 parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The SF was given information on counseling services and funeral assistance was provided following the death of the children.

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 was no known CPS history outside of 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