Child Fatality Report

Report Identification Number: SV-23-047

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

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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 **Jurisdiction:** Westchester **Date of Death:** 08/05/2023
Age: 4 month(s) **Gender:** Female **Initial Date OCFS Notified:** 08/05/2023

Presenting Information

An SCR report alleged that the mother was struggling with postpartum depression after the birth of the 4-month-old female subject child. On 8/05/23, the grandparents were in the home with the mother and child. One of the grandparents fed the child at 6:20 AM and put her back in her bassinet. The mother then entered the child's room at 6:45 AM with a firearm. The mother shot the child in the head and then herself in the head, killing them both. The grandparents called 911 at 7:07 AM after hearing the second gunshot. Emergency medical services arrived at the home at an unknown time, but no medical interventions were able to be performed. Upon their arrival, the child was still lying on her back in the bassinet. The mother was lying on the floor near the bassinet.

Executive Summary

This fatality report is regarding the death of a 4-month-old female child that occurred on 8/5/23. A report was made to the SCR on the same day and alleged DOA/Fatality, Internal Injuries, and Inadequate Guardianship against the mother regarding the subject child. The child resided with her parents and there were no siblings.

Westchester County Department of Social Services (WCDSS) and law enforcement investigated the death. It was learned that following the birth of the child, the mother began exhibiting symptoms of depression. The mother had two inpatient hospitalizations and received outpatient services at the time of her death. The mother was diagnosed with postpartum psychosis. The father was an active participant in the mother's treatment planning. There was a plan in place through mental health providers that the mother was not to be the sole caretaker of the child. On 8/4/23, the father was out of town attending a concert. The mother and child stayed home, and the maternal grandparents stayed at the home for the weekend. On the morning of 8/5/23, the mother fed the child a bottle and then left the home to walk the dog. The mother returned and went upstairs to change. Shortly after, the grandparents heard gunshots from upstairs and the sound of something falling. The child's door was locked and the grandfather kicked it open. The mother was unresponsive on the floor and the child was dead inside of the bassinet. Emergency medical services arrived at the home but no medical interventions were able to be performed, as the mother and child were deceased.

An autopsy was performed and the final results were not yet available at the time the CPS investigation was closed. Law enforcement investigated the fatality; however, there were no criminal charges as the mother was deceased. It was determined the mother covered the child's head with a pillow and shot her in the head through the pillow. The mother then shot herself and died.

WCDSS offered the father and grandparents grief counseling services. WCDSS substantiated the allegations against the mother. It was determined that the mother was not adhering to her treatment regime, leading to her mental instability and the death of herself and the child. WCDSS added and substantiated Inadequate Guardianship against the father. It was determined that the father was aware of the mother's mental health condition and suicidal ideation, yet chose to store his gun and ammunition in the home safe that the mother had access to. Though the father hid the magazine of the gun in the home, the father gave the mother a general area of where it was stored. In addition, the father showed the mother how to use the gun. The mother used the gun to kill the child and then herself. WCDSS determined that the father's actions were neglectful and placed the child at serious risk of harm. The investigation was indicated and closed on 10/4/23.

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 other children; therefore, the completion of safety assessment tools was not required. WCDSS supported their determination with the information gathered during the investigation.

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 was commensurate with 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: 08/05/2023 **Time of Death:** 06:45 AM (Approximate)

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: 07:07 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
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: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	40 Year(s)

LDSS Response

Upon receipt of the SCR report on 8/5/23, WCDSS immediately initiated their investigation, coordinated efforts with LE, spoke with the ME and DA’s offices of the death, completed interviews with the family, and offered appropriate services.

WCDSS and LE interviewed the grandparents, who confirmed they were at the home with the SM so the SF could attend a concert. The grandparents reported the SF was reluctant to leave the SM, but the family encouraged him to go. The grandparents were aware of the SM’s mental health diagnoses. On the day of the death, the MGM prepared a bottle for the SC and brought it upstairs. The SM insisted on feeding the SC and did so in the nursery. Neither grandparent remained in the room while she fed the SC. The MGM went downstairs to watch the news and the MGF was still asleep. After she fed the SC, the SM came downstairs to log the feeding into the book. The family typically logged the child's feedings and diaper changes. The SM informed the MGM that she was taking the SC to a birthday party later on in the day. The SM then went to walk the dog. The SM returned home from walking the dog, she went upstairs and changed her clothes. The SM was then trying to put the SC to sleep. The MGM stated that shortly after the SM went upstairs she heard a bang like something fell and she ran up to check. The MGF heard two bangs and then heard something fall. The MGF stated that he had to kick the door in three times before he was able to gain access to the room. Once in the room, they saw the SM on the floor unresponsive and the SC dead inside her crib.

The SF reported he got a gun for protection purposes and it was licensed. The SM was not licensed to use the gun. The SF purchased a pistol a month prior to the SC’s death. The SF had dummy rounds for practice and taught the SM how to use the gun. The gun was stored in a safe in his closet with two boxes of ammunition and there was additional ammunition kept in another part of the home. The magazines were hidden behind the electrical closet in the basement and the SF reported the SM must have gone and looked for them. WCDSS obtained information regarding obtaining a gun license and learned that there is a 16-to-18-hour mandatory course for all applicants where the rules regarding guns and gun safety were taught. A licensed person was not allowed to show a non-licensed person how to use their gun or give them access to their gun. Instruction included that any gun was to be secured appropriately from every person in the home who was not licensed to use the gun. The application had pages where warnings were printed.

WCDSS completed interviews with and gathered records from the SM's mental health providers. In May 2023, the SM was hospitalized and diagnosed with Postpartum Psychosis and Adjustment Disorder. The SM was released with a referral for outpatient treatment. The SM was still showing symptoms of psychosis and was hospitalized a second time through June 6, 2023. Outpatient services reported explaining to the SF at that time that when untreated with medications, a

diagnosis of postpartum psychosis posed a risk of suicidality and/or infanticide. The SF denied receiving this information. Following the SM's discharge, the SM returned to outpatient treatment, where she continued to be diagnosed with Postpartum Psychosis, Other Obsessive-Compulsive Disorder, and Anxiety Disorder. The outpatient program was responsible for therapy and medication. The SF was actively involved in the SM's treatment and was supposed to administer the SM's medication. The SM began self-administering her medication and had not been compliant with her medicine in the weeks leading up to the SC's death, which the SF reported they were monitoring at home. The SM was intended to be on medication for a minimum of a year with a taper off of it when deemed appropriate.

Once all interviews were completed with family and collaterals, the investigation was indicated and closed.

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? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065570 - Deceased Child, Female, 4 Month(s)	065571 - Mother, Female, 40 Year(s)	DOA / Fatality	Substantiated
065570 - Deceased Child, Female, 4 Month(s)	065571 - Mother, Female, 40 Year(s)	Inadequate Guardianship	Substantiated
065570 - Deceased Child, Female, 4 Month(s)	065571 - Mother, Female, 40 Year(s)	Internal Injuries	Substantiated
065570 - Deceased Child, Female, 4 Month(s)	065572 - Father, Male, 37 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?	☒	☐	☐	☐

Additional information:
The mother was deceased and unable to be interviewed.

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	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The father reported he was enrolled in grief counseling services. The grandparents were offered fatality-related services. The grandmother agreed to enroll and the grandfather declined.

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

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

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

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