

Report Identification Number: NY-21-044

Prepared by: New York City Regional Office

Issue Date: Oct 14, 2021

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 <u>only</u> 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						
DrDoctor	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	ACS-Administration for Children's	NYPD-New York City Police						
Service	Services	Department						
PPRS-Purchased Preventive	TANF-Temporary Assistance to Needy	FC-Foster Care						
Rehabilitative Services	Families							
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	ASTO-Allowing Sex Abuse to Occur							



Case Information

Report Type: Child Deceased
Age: 1 month(s)

Jurisdiction: Queens
Gender: Female

Date of Death: 04/22/2021,estimated
Initial Date OCFS Notified: 04/22/2021

Presenting Information

The SCR registered five reports regarding the deaths of the one-month-old children. According to the information received, on an unknown date between 04/19/21 and 04/22/21, the mother murdered her one-month-old twin children. On 04/22/21, a family member could not reach the mother by phone. The family member went to the home, but no one came to the door. The family member notified the authorities at about 3:12PM to do a welfare check. At approximately 3:22PM, first responders went to the home and found both children deceased. The male child was found in a bassinet, with a knife in his neck, while the female child was found with scalding injuries under the kitchen sink cabinet, wrapped in a plastic bag. The mother admitted to giving the twins formula that she laced with Pine Sol. She also admitted to holding the female child under hot scalding water. The mother admitted that she killed the twins.

Executive Summary

This fatality report concerns the death of a one-month-old female subject child that occurred sometime between 4/19/21 and 4/22/21. The child's body was discovered on 4/22/21. A report was made to the SCR on that same date with allegations of DOA/Fatality, Burns, Scalding, Inadequate Food/Clothing/Shelter, and Inadequate Guardianship of the female subject child, and DOA/Fatality, Inadequate Food/Clothing/Shelter, and Inadequate Guardianship her deceased twin sibling by the mother. The Administration for Children's Services (ACS) received the report and investigated the death of the child. An autopsy was completed, and while the official cause and manner of death had not yet been released at the time of this writing, preliminary results noted the manner of death for the child was homicide.

At the time of her death, the child resided with her mother and twin male sibling.

ACS's investigation revealed over a period of days before 4/22/21, the mother fed the child Pine Sol then took the child to the bathroom where she filled the tub with hot water and immersed the child in the water. Afterwards she removed the child's body, wrapped her in a blanket, and placed her in a black garbage bag for disposal. The bag with the child's body was placed under the kitchen sink.

On 4/22/21, a relative went to the home to retrieve mail and when asked about the children he was told the children were with their father. After other statements made by the mother, the relative found the body of the male child in the bedroom and called for emergency services. Upon arrival, the EMS asked about the female child and at that time the mother indicated the child's body was under the sink in the kitchen. When law enforcement arrived, the mother was questioned. The mother said she did not want the children anymore so they were dead.

The mother was arrested and charged with Murder in the First Degree - Multiple Victims, Murder with Intent, and Acting In a Manner Injurious to a Child Less Than 17 years old.

There were several court hearings following the discovery of the bodies of the children. At the 6/2/21 hearing, the mother was deemed unfit for trial and was remanded to the Commissioner of Mental Health. There were no additional court dates scheduled.

Throughout the investigation, ACS maintained contact with law enforcement, medical professionals including the Medical Examiner, and family members. The information obtained from these collaterals reflected the mother's actions directly caused the death of the child.

NY-21-044 FINAL Page 3 of 10



On 6/22/21, ACS substantiated the allegations of DOA/Fatality, Burns and Scalding, and Inadequate Guardianship of the one-month-old female child by the mother. ACS documented there was some credible evidence to support the substantiation of the allegation and cited the Medical Examiner's statements regarding the slippage of the child's skin due to the hot water burns, and the presence of Pine Sol in the child's body.

ACS unsubstantiated the allegation of Inadequate Food, Clothing, and Shelter on the basis of no credible evidence and cited information from detectives that there was an ample supply of food and clothing for the children in the home.

The mother remained incarcerated as of the writing of this report.

Findings Related to the CPS Investigation of the Fatality

Safety Assessmen	ıt:
------------------	-----

- 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 surviving siblings or children in the home; therefore no safety assessments were necessary.

Was the decision to close the case appropriate?

Yes

Was casework activity commensurate with appropriate and relevant statutory Yes

or regulatory requirements?

Was there sufficient documentation of supervisory consultation?

Yes, the case record has detail of the

consultation.

Explain:

During the course of the investigation, there was documentation of supervisory consultation. The level of casework activity, which included contact with the family and others from the receipt of the report through case conclusion, was commensurate with the case circumstances.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? \(\subseteq \text{Yes} \) \(\subseteq \text{No} \)

Fatality-Related Information and Investigative Activities

NY-21-044 FINAL Page 4 of 10



	11	ncident information							
Date of Death: 04/22/2021 D	Pate of Death: 04/22/2021 Date Estimated Time of Death: Unknown								
Γime of fatal incident, if diff	Unknown								
County where fatality incide	ent occurred:		Queens						
Was 911 or local emergency	number called?		Yes						
Гime of Call:			03:12 PM						
Did EMS respond to the sce	ne?		Yes						
At time of incident leading t	o death, had child use	ed alcohol or drugs?	No						
Child's activity at time of incident:									
☐ Sleeping	Working	g Drivi	ng / Vehicle occupant						
Playing	Eating	Unkn							
Other	_ 6	_							
Did child have supervision a	at time of incident lead	ling to death? Yes							
At time of incident was supe		_							
At time of incident supervisor	-								
Distracted)1 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Absent							
Asleep		Other:							
Asicep		Other.							
Fotal number of deaths at ir	icident 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	1 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Deceased Child's Household	Other - Deceased twin sibling	Alleged Victim	Male	1 Month(s)

LDSS Response

Upon receipt of the reports, the Specialist contacted family members, spoke with law enforcement and the medical examiners who conducted the autopsies for the children. The investigation adhered to protocols in place for the investigation of the report.

On 4/23/21, the Specialist attempted a home visit; however law enforcement barred the entry into the home as the case address was deemed a crime scene. Law enforcement informed ACS there was an ample supply of food and clothing for the children, the home was neat. Additionally, there were two bassinets in the home and two car seats for the children. Law enforcement confirmed there were no other children in the home and no surviving siblings.

The Specialist contacted the mother's cousin who made the discovery regarding the death of the children. According to the NY-21-044 FINAL Page 5 of 10



cousin, on 4/22/21 he went to the case address to collect his mail and when he arrived, he saw the mother. The cousin said he asked about the children and the mother said they were with their father. The cousin said he was alarmed as it was known throughout the family, that the father of the subject children was unknown. The cousin said he asked the mother about the children again when he noticed the children's car seats in the home. At that time the mother told him the male infant was in the bedroom. The cousin said when he entered the room, and pulled the sheets from the covered bassinet, he observed the child with a knife in the back of his head. The cousin said he called 911. When EMS arrived they questioned the mother about the location of the female child. The mother used her foot to motion to a kitchen cabinet where the technician discovered the female child wrapped in a black plastic bag.

The Specialist contacted the hospital where the twins were born, to obtain information regarding any prenatal care, discharge plan and clinical health treatment for the mother. Later in the investigation ACS obtained the documents which reflected the mother's lengthy clinical health history.

Law enforcement also indicated the mother was arrested at the scene on 4/22/21. Further, law enforcement indicated two calls had been made regarding the family; the first was for a welfare check as no one had heard from the mother in a few days and she was not responding to any calls. The second call was for 911 to respond to the case address as the body of one child was observed and the immediate whereabouts of the other were not known.

The Specialist spoke with law enforcement personnel who confirmed the mother made a full confession that was videotaped. Details regarding the statement were not immediately shared; however, later in the investigation ACS learned the mother said she did not want the children any more so they were dead. The mother admitted to killing the children and provided details regarding the death of the children.

On 4/23/21, the Specialist contacted the Medical Examiner and learned that from preliminary findings the female child was held under scalding hot water. There were also signs of asphyxia. The male child was found with a knife stuck in the back of his neck. His vertebrae was severed. The Medical Examiner said the mother admitted to feeding the children Pine Sol before killing them. The Medical Examiner said the manner of death for the children was homicide.

On 4/26/21, the mother was arraigned and charged with Murder in the First Degree with Intent, two counts of First Degree Felony Murder - Multiple Victims, and two misdemeanor counts of Acting in a Manner Injurious to a child under 17 years old. The mother was taken to the hospital for a clinical evaluation on 4/26/21, after appearing in court. The mother was not allowed to have any visitors, including ACS staff. The mother was remanded to the Commissioner of Mental Health and remained incarcerated in the hospital.

On 6/21/21, ACS indicated the report and closed the case as there were no surviving siblings and the mother was incarcerated.

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 reviewed by an OCFS approved Child Fatality Review Team?No

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

NY-21-044 FINAL Page 6 of 10



SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
058425 - Deceased Child, Female, 1 Mons	058427 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
058425 - Deceased Child, Female, 1 Mons	058427 - Mother, Female, 23 Year(s)	Burns / Scalding	Substantiated
058425 - Deceased Child, Female, 1 Mons	058427 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
058425 - Deceased Child, Female, 1 Mons	058427 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
058426 - Other - Deceased twin sibling, Male, 1 Month(s)	058427 - Mother, Female, 23 Year(s)	DOA / Fatality	Substantiated
058426 - Other - Deceased twin sibling, Male, 1 Month(s)	058427 - Mother, Female, 23 Year(s)	Inadequate Guardianship	Substantiated
058426 - Other - Deceased twin sibling, Male, 1 Month(s)	058427 - Mother, Female, 23 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?			\boxtimes	
When appropriate, children were interviewed?			\boxtimes	
Alleged subject(s) interviewed face-to-face?		\boxtimes		
All 'other persons named' interviewed face-to-face?			\boxtimes	
Contact with source?	\boxtimes			
All appropriate Collaterals contacted?	\boxtimes			
Was a death-scene investigation performed?		\boxtimes		
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?	\boxtimes			
Was there timely entry of progress notes and other required documentation?	\boxtimes			

Additional information:

The Specialists attempted to complete a death scene investigation; however, they were barred from doing so by law enforcement. Law enforcement provided details regarding the scene and information from the mother's taped interviews.

Fatanty Safety Assessment Activities									
	Yes	No	N/A	Unable to Determine					

NY-21-044 FINAL Page 7 of 10

NEW YORK STATE	Office of Children and Family Services
----------------------	--

Were there	any surviving siblings o							
		Legal Activity Related to the Fat	ality					
Was there legal activity as a result of the fatality investigation? ☐ Family Court ☐ Order of Protection								
Criminal Cl	harge: Murder Degre	ee: 1						
Date Charges Filed:	Against Whom?	Date of Disposition:	D	isposition	:			
Unknown	The mother. 04/26/2021 Mother incarcerated							
Comments:	The mother was charged with Murder in the First Degree with Intent, 2 counts of First Degree Felony Murder - Multiple Victims, 2 misdemeanor counts of Acting in a Manner Injurious to a child under 17 years old.							

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						\boxtimes	
Health care							
Legal services						\boxtimes	
Family planning							
Homemaking Services							
Parenting Skills							
Domestic Violence Services							
Early Intervention							
Alcohol/Substance abuse						\boxtimes	
Child Care						\boxtimes	
Intensive case management						\boxtimes	

NY-21-044 FINAL Page 8 of 10

New YORK and Family Services Child Fatality Report									
Family or others as safety resources									
Other									
Additional information, if necessary:									
No services were provided as the mother w	as incarcer	ated after th	ne fatalities.						
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? N/A Explain: There were no surviving siblings or other children in the household. Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No Explain: The mother was arrested and charged with the murders of her children. The mother was subsequently hospitalized then									
incarcerated.	TT* /	D • 4 4	I F / 1º/						
	History	Prior to t	he Fatality	Y					
	C	hild Informa	ation						
Did the child have a history of alleged ch Was the child ever placed outside of the Were there any siblings ever placed outs Was the child acutely ill during the two v	home prior ide of the h	r to the dea nome prior	th?	d's death?		No No No No			
	Infants	S Under One	Year Old						
During pregnancy, mother: Had medical complications / infections Misused over-the-counter or prescription drugs Experienced domestic violence Was not noted in the case record to have any of the issues listed									
Infant was born: ☐ Drug exposed ☐ With fetal alcohol effects or syndrome ☐ With neither 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 - Investigati	ve History N	More Than T	Three Years I	Prior to the	Fatality				
There was no CPS investigative history mor				*					
NIV 21 044	Known CP	S History O	utside of NY	3		Dogo 0	610		

FINAL Page 9 of 10 NY-21-044



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