Child Fatality Report

Report Identification Number: NY-18-024

Prepared by: New York City Regional Office

Issue Date: Sep 10, 2018

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: 1 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 03/14/2018
Initial Date OCFS Notified: 03/14/2018

Presenting Information

On 3/14/18 at 4:44 AM, the PGM returned home and found the PGF bleeding in the bathroom, the SF and the one-year-old SC in the left bedroom and the sixteen-year-old paternal uncle in the rear bedroom bleeding. The PGM contacted 911 at approximately 5:00 AM. Upon arrival, the SC, sixteen-year-old, SF and the PGF were pronounced deceased at 5:17 AM from gunshot wounds to the head. It is believed that the SF murdered the two children, PGF and then committed suicide.

Executive Summary

This one-year-old female (SC) died on 3/14/18. ACS initiated the investigation by contacting LE who responded to a 911 call at the case address at 5:00 AM. LE reported the PGM arrived home at 4:44 AM on the above date to find the SC, sixteen-year-old male, the SF and the step-PGF bleeding and unresponsive. The allegations of the report were DOA/ Fatality and IG of the SC by the SF and DOA/ Fatality and IG of the sixteen-year-old PU by the SF (his brother).

LE reported the PGM found the SC on the SF's bed, unresponsive. As she attempted to revive the SC, she observed the SF lying on the floor next to the bed, bleeding and unresponsive with a gun next to him. The PGM then observed the sixteen-year-old lying on the bottom bed of the bunk in his bedroom with a pillow covering his face and the step-PGF on the bathroom floor unresponsive. LE initially reported it appeared the SF killed his family members that were in the home that night and committed suicide. LE later confirmed with the results of their investigation.

ACS interviewed the BM, PGM, PU and other family members. The PGM admitted she kept the SF's clinical diagnosis between immediate family, the BM and PU reported they were unaware. However, the PGM, BM and PU all acknowledged the SF exhibited signs of depression, anger and behavioral issues. They disclosed they were aware the SF consumed alcohol, kept a firearm in the home and used marijuana. The BM knew the SF was not himself based on their conversation earlier when she rejected his request to rekindle their relationship. During his visit that night, the PU felt the SF want to tell him something but could not, as they consumed alcohol. The extended family member disclosed her concern for the SF well being after a brief conversation on the night before the incident. However, with so many signs, none considered the safety of the children in the home with the SF.

The BM's six-year-old sibling was monitored and supported by the school staff, who reported he was doing well, his father and a host of family members. ACS referred the sibling and the BM for services but they parents declined.

The ME reported the cause of the SC's death was gunshot wound with injury to the head and the manner of death a homicide.

On 6/5/18, ACS substantiated the allegations of DOA/Fatality and IG of the SC and the sixteen-year-old citing the results of the autopsy and the results of the investigation completed by LE.

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:
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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: 03/14/2018 **Time of Death:** 04:44 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 05:00 AM
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? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Unknown if they were impaired.

Total number of deaths at incident event:
Children ages 0-18: 2
Adults: 2

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	54 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	56 Year(s)
Deceased Child's Household	Other Deceased Child - Sibling of SF/Uncle of SC	Alleged Victim	Male	16 Year(s)

LDSS Response

The SCR registered a report of the death of the one-year-old female SC on 3/14/18. The report alleged that the SF shot and killed the SC, sixteen-year-old (half-brother), step-PGF, then turned the gun on himself. The allegations of the report were DOA/fatality and IG of the SC and sixteen-year-old by the SF who is the half-sibling of the sixteen-year-old. ACS initiated an investigation into the death of the children by contacting LE and the office of the ME.

LE reported that on 3/14/18, at approximately 5:00 AM, they responded to a 911 call from the case address. Upon their arrival, they met with the PGM who, upon her return, made the discovery. LE observed the step-PGF in the bathroom bleeding, the sixteen-year-old in his bedroom on the bottom bunk and his face was covered with a pillow, the SC on the bed in the rear bedroom along with the SF on the floor bleeding. According to LE, the PGM found a gun next to the SF and moved it to her bedroom. She had no explanation as to the reason she move the gun; however, she believed someone entered the home and killed her family.

LE reported the results of their investigation was a triple homicide suicide. LE found no one entered the home during the night except for the SF who repeatedly went outside to smoke. LE confirmed that the PU visited the home and left with his one-year-old son earlier that night.

The ACS Specialist interviewed the BM of the SC on 3/15/18, 3/20/18 and 4/2/18. The BM reported she allowed the SC to spend many nights and days with the SF. The BM told the Specialist she was unaware of the SF's mental health condition; however, she observed that when he became angry, it was very difficult and took a long time for him to calm down. She also disclosed that after a forty-five minute video conversation with the SF on the night before the incident, he appeared "zoned out," distant and aloof. In addition she declined his offer to visit the home that night and to rekindle their relationship. The BM disclosed the SF had marijuana, guns and a large sum of cash in the home and that he was always at home.

The BM also has a six-year-old son from a prior relationship who spends most of his time with his biological father. ACS documentation reflects the six-year-old half sibling was doing well in school and because of the death of the SC his mental well being was being monitored by school staff.

On 3/15/18, ACS interviewed the PGM and PU. The PGM confirmed the report given by LE. The PGM explained that the SF was diagnosed with a mental health condition in 2013 and was taking prescribed medication. The SF was hospitalized for one week in 2014; however, in 2015 he stopped taking the medication because of the side effects. The PGM described episodes of behavioral changes and bouts of depression the SF experienced. The PGM admitted she knew the SF was

selling marijuana from the home and that he had been smoking it as well. She was aware that the SF kept a firearm in the home and yet she thought it safe to leave the children in his care. When asked about the many domestic violence incidents in the home, the PGM responded “yes but not real issues”, a reflection of her naivety that inhibited her ability to provide adequate guardianship for the children.

On 3/14/18, ACS interviewed the PU who visited the home earlier in the night prior to the incident. He denied knowledge of his brother’s mental health condition. The PU said he visited the SF because he was aware his brother was depressed. He felt the SF wanted to tell him something but could not bring himself to say; however, he gave no indication that he would hurt anyone, and there were no fights in the home. They shared drinks that night and he left with his son.

On 3/19/18, the ME reported the preliminary cause of the SC’s death was gunshot wound to her head and the manner of death a homicide.

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: The New York City region does not have a Multidisciplinary Team. The ACS investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? Yes
Comments: The New York City region does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046965 - Deceased Child, Female, 1 Yrs	046966 - Father, Male, 26 Year(s)	DOA / Fatality	Substantiated
046965 - Deceased Child, Female, 1 Yrs	046966 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
047437 - Other Deceased Child - Sibling of SF/Uncle of SC, Male, 16 Year(s)	046966 - Father, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
047437 - Other Deceased Child - Sibling of SF/Uncle of SC, Male, 16 Year(s)	046966 - Father, Male, 26 Year(s)	DOA / Fatality	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?	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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:
ACS case documentation does not reflect the Specialist attempted to retrieve medical information from the one-year-old SC's pediatrician.

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 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 six-year-old sibling received support services from his school staff.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The BM and PGM declined services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was there an open CPS case with this child at the time of death? 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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/06/2015	Aunt/Uncle - Cousin, Male, 14 Years	Grandparent, Male, 55 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
On 7/6/2015, at approximately 7:00 PM, the step-PGF was a passenger in a vehicle that he allowed the then fourteen-year-old male cousin to drive. Consequently, the fourteen-year-old caused a motor vehicle accident with a second vehicle and the occupant got injured; however, he was not injured. The report alleged IG of the fourteen-year-old by the step-PGF.

The investigation revealed that the step-PGF was arrested and an OP was filed on behalf of the fourteen-year-old. The step-PGF had initially agreed to PPRS; however, after the case and the OP were dismissed, he declined services.

Report Determination: Indicated | **Date of Determination:** 08/19/2015

Basis for Determination:
ACS substantiated the IG allegation of the then fourteen-year-old by the step-PGF citing LE reported he was arrested and charged with endangering the welfare of a child. ACS wrote that the step-PGF allowed the fourteen-year-old to operate a motor vehicle without a license and as a result caused an accident.

OCFS Review Results:
The determination was appropriate.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

On 12/10/2002, the SCR registered a report alleging that the step-PGF was angry and struck his then 12-year-old step son (BF) with a screw driver causing a laceration. The allegations were LBW of the then 12-year-old by the step-PGF. ACS' case investigation revealed that the 12-year-old child and the step-PGF had an altercation resulting in a small laceration to the child's right arm. LE arrested the step-PGF and he was later released with a limited OP on behalf of the child. The BM was at work at the time of the incident.

ACS documented that at the time of determination, the family's functioning was still chaotic as the child exhibited behavioral issues and the parents had declined preventive services. ACS obtained a legal consultation which resulted in the parents obtaining a "Person In Need of Service" petition, in addition to the counseling in school, for the child. On 2/03/03, ACS substantiated the allegations and the case remained open with continued services.

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