Child Fatality Report

Report Identification Number: NY-18-023

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		

Case Information

Report Type: Child Deceased
Age: 16 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 03/14/2018
Initial Date OCFS Notified: 03/14/2018

Presenting Information

On 3/14/18 at 4:44 AM, the BM arrived home and found the BF bleeding in the bathroom, the one-year-old SC was in the front left bedroom bleeding and the sixteen-year-old male SC in the rear bedroom bleeding. The BM contacted 911 at approximately 5:00 AM. The BF, one-year-old child and the sixteen-year-old SC were pronounced dead from gunshot wounds to the head at 5:17 AM. It was believed the adult sibling murdered the two children and the BF, then committed suicide.

Executive Summary

According to LE, the adult sibling (AS) shot his sixteen-year-old brother (SC), his one-year-old daughter (SC's niece), his step-father and himself on 3/14/18. The BM was not home at the time of the incident; she returned at 4:44 AM to find everyone in the home unresponsive. The BM summoned LE who responded and initiated a criminal investigation. The SCR registered the report with allegations of DOA/Fatality and IG of the SC and the one-year-old child by the AS.

The ME reported the SC died as a result of injury from a gunshot to the head and chest. The one-year-old child, step-father, and AS also died as a result of injury from a gunshot wound to their heads.

LE reported the BM left the home at 11:08 AM and the SC's eldest sibling (ES) visited the home earlier that night to pick up his one-year-old son. According to LE, the ES left the home at 9:00 PM and no one else entered the home that night. LE also reported the family had twenty-five incidents of domestic violence with some ending in arrest; the last DV incident occurred on 10/11/17 with the BM as the suspect and the BF, the victim.

On the following day, the ACS Specialist interviewed the BM and the ES and they both admitted they were aware the AS smoked marijuana, drank alcohol and kept a firearm in the home. The eldest sibling visited the AS earlier that night because the AS sounded depressed when they last spoke on the phone. He shared a few drinks with the AS before he left with his son. He reiterated that there were no arguments in the home when he visited. The BM knew the environment was dangerous and that the AS had an untreated mental health condition and exhibited signs of depression and unusual behavior; however, she failed to take any action to rectify the situation and protect all the residents of the home. ACS assisted the BM with burial funds for the SC.

The Specialist interviewed the mother of the one-year-old deceased SC and she stated she spoke to the AS earlier on the day of the incident and he appeared distant. She reported she declined his invitation to visit the home that day and he did not disclose any thoughts of harm.

During the investigation it was revealed the mother also has a six-year-old male child from a previous relationship. ACS offered services to the mother and the six-year-old SS; however, the mother declined. The six-year-old SS attended school regularly, the immunizations were current and there were no safety concerns for this child.

ACS substantiated all allegations of the report citing the results of LE and the autopsy report from the office of the ME; however, ACS did not establish whether the AS was a person legally responsible for the SC and the allegation of IG of the SC by the AS should have been unfounded.

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?** 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? 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:
The determination was appropriate and there were minors or other children in the household.

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 2
At time of incident supervisor was: Not 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	Adult Sibling	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Father	No Role	Male	58 Year(s)
Deceased Child's Household	Mother	No Role	Female	54 Year(s)
Deceased Child's Household	Other Child - Child of Adult Sibling	Alleged Victim	Female	1 Year(s)

LDSS Response

On 3/14/18, ACS responded to the report registered by the SCR regarding the death of a 16-year-old male. ACS obtained information from the first responders, ME and BM. According to LE, sometime during the early morning hours, the adult sibling (AS) killed his one-year-old daughter, 16-year-old brother, step-father and then himself. The BM was not at home at the time of the incident. ACS learned that the AS failed to follow the course of treatment for a diagnosed mental condition; instead, he self-medicated with alcohol and marijuana. Additionally, he attempted to rekindle the relationship with his one-year-old child's mother and she rejected him.

The ME reported the cause of death of the SC was a gunshot wound with injury to the brain, aorta and right lung. The cause of death of the one-year-old was a gunshot wound to the head; their deaths were ruled homicides.

ACS contacted LE who responded to a 911 call from the home at 5:00 AM; they declared the home a crime scene. ACS viewed pictures and obtained information. ACS learned that the BM arrived home at approximately 4:44 AM and observed the one-year-old laying on the bed unresponsive; as she attempted to revive the child, she noticed the AS on the floor with a gun next to him. She took the gun to her bedroom and observed her husband (BF) on the bathroom floor, bleeding. The BM proceeded to the SC's bedroom and found him on the bottom bunk bed with a pillow covering his face. LE investigation revealed the eldest sibling (ES) left the apartment with his son earlier that night and no one entered the apartment afterwards. Also, the AS went outside to smoke three times during that night.

ACS interviewed the BM who admitted she knew the AS had stopped taking his medication, possessed a gun, and smoked and sold marijuana from the home. The BM was aware that the AS had been exhibiting mood changes. The BM explained that the family had a history of multiple arguments that ensued into fights resulting in police intervention and that "they were not real issues." The case documentation reflected the SC attended school and was performing on grade level.

On 3/14/18, ACS interviewed the ES, who had visited the home earlier that night. The ES denied knowledge of his brother's mental health condition; however, he visited because his brother was depressed. He said they had a few drinks and the AS wanted to tell him something but did not. The ES admitted that he knew there was a gun in the home; however, he was adamant that no argument or fight ensued during his visit. He said the BM was not at home when he left with his son. The ES reiterated that the one-year-old child was in the care of the AS more often than with her mother who knew he was volatile.

On 3/15/18, 3/20/18 and 4/2/18, ACS interviewed the mother of the one-year-old deceased child and she stated the child resided with her but she allowed her to spend some nights and weekends with her father (AS). She stated she was unaware the AS had a mental condition. She said she spoke to him via video from 9:45 to 10:30 PM that night and he appeared "zoned out." He asked her to rekindle their relationship and she declined. The mother stated that during their conversation, there were intervals of silence, as if he wanted to tell her something but could not express it. She revealed the AS kept two guns, a large sum of money and marijuana in the home. She believed he was not affiliated with a gang as he was always at home and had no visitors. The mother mentioned that her own mother conversed with the AS via video and was concerned that he appeared "distant." The mother declined services and her six-year-old son's mental well being was being monitored by the school staff.

On 6/5/18, ACS substantiated all allegations citing the results of the autopsy and LE's investigation.

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.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
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
046959 - Deceased Child, Male, 16 Yrs	047435 - Adult Sibling, Male, 26 Year(s)	DOA / Fatality	Substantiated
046959 - Deceased Child, Male, 16 Yrs	047435 - Adult Sibling, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
047436 - Other Child - Child of Adult Sibling, Female, 1 Year(s)	047435 - Adult Sibling, Male, 26 Year(s)	Inadequate Guardianship	Substantiated
047436 - Other Child - Child of Adult Sibling, Female, 1 Year(s)	047435 - Adult Sibling, 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?	☒	☐	☐	☐
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:
The only subject of the report is deceased.

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? N/A
Explain:
There were no surviving siblings in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The BM declined services. The mother of the one-year-old child also declined services for the six-year-old half-sibling.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
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	Deceased Child, Male, 14 Years	Father, Male, 55 Years	Inadequate Guardianship	Substantiated	No

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

The investigation revealed the BF was arrested and an OP was filed on behalf of the SC. The BF had initially agreed to PPRS services. The BF declined services after the criminal case and the order of protection were dismissed.	
Report Determination: Indicated	**Date of Determination:** 08/19/2015
Basis for Determination: ACS substantiated the IG allegation of the SC by the BF citing that LE reported the BF was arrested and charged with endangering the welfare of a child. ACS documented the BF allowed the SC to operate a motor vehicle without a license and as a result caused an accident and injury to another driver.	
OCFS Review Results: The investigation was complete and the determination appropriate.	
Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No	

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

There is no ACS history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is 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