Child Fatality Report

Report Identification Number: SV-18-036

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

Issue Date: Oct 17, 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: 2 year(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 06/06/2018
Initial Date OCFS Notified: 06/06/2018

Presenting Information

An SCR report received on 06/06/18 alleged the subject father picked up the subject child for his visit on 06/05/18 and failed to return him to the mother yesterday evening as he was supposed to. Both the father and child were found dead in the father's vehicle in Rockbridge County, Virginia today, 06/06/18. The SC was in the care of the father when he died, so the father was being held responsible for the death. No further details were available.

Executive Summary

This report concerns the death of the 2-year old male SC. On 06/06/18, Suffolk County Department of Social Services (SCDSS) received an SCR report regarding the fatality, subsequent to an open CPS investigation.

SCDSS promptly contacted LE upon receiving notification of the SC's death and worked in conjunction with local LE, as well as LE in the jurisdiction where the bodies were discovered. There were no criminal charges associated with the fatality.

It was determined that there were no minor SS or other children living in the SC's home.

The ME's office of the Western District of Virginia was notified and an autopsy was performed by a pathologist. SCDSS obtained the autopsy report, which listed the cause of death as "gunshot wound of head" and the manner of death as homicide. The father was also discovered in the vehicle, and his death was due to a self-inflicted single gunshot wound to his head.

SCDSS interviewed the BM, the adult sibling and his partner. They were unable to provide any information as to why the SF would have acted in such a manner, aside from an approaching court hearing regarding an ongoing custody battle. The BM stated that she had a feeling the SF would shoot their son and then himself; however, she had no evidence to support the fatal incident would take place. She denied knowing of any MH condition that SF may have had, yet was aware he had a firearm.

SCDSS completed all the safety assessments and other reports in a timely manner. The allegations within the report were substantiated against the SF, though the incident took place outside of New York State jurisdiction, and the father was deceased.

SCDSS appropriately offered grief and bereavement counseling, funeral assistance, and mental health services to the family. Additionally, SCDSS assessed the BM's need for substance abuse counseling. BM declined counseling services for herself and the adult sibling, as they were involved elsewhere.

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?** No

Explain:
There were no surviving children. SCDSS substantiated the allegations against the SF, although the fatal incident took place out of NYS jurisdiction.

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 decision to close the case was appropriate.

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: 06/06/2018 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Out Of State
Was 911 or local emergency number called? Yes
Time of Call: 07:50 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
At time of incident supervisor was: Unknown if they were impaired.

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	Male	2 Year(s)
Deceased Child's Household	Mother	No Role	Female	42 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	46 Year(s)

LDSS Response

At the time of the fatality, there was an open investigation, dated 05/25/18, concerning SF being unable to care for SC due to drug abuse and using excessive corporal punishment on the SC, causing bruises. BM was alleged to improperly supervise SC and to have caused bruising to SC.

SCDSS began their investigation into the fatality on 06/06/18, after receiving an SCR report. SCDSS contacted the source of the report, checked CPS history, notified the DA, and contacted local LE as well as LE in the jurisdiction where the fatal incident occurred. There was an ongoing custody battle at the time of the fatality, with court scheduled for 06/07/18.

It was learned by SCDSS that SF had no other children and BM had an adult son. He did not live in SC's home, nor did any other children.

SCDSS spoke with BM on 06/07/18, in her home. The adult brother and his partner were present to provide support to the BM. BM described a timeline of events leading up to the time she learned of the fatality. BM said she brought SC to SF's house on 06/06/18 at 7:00AM, as scheduled. She recalled SF being nicely dressed and well groomed. She found this "odd" as this was atypical for him. BM expected SC to be returned to her between 3:30 and 4:00PM, which did not happen. At 4:12PM, she texted SF. The texts were not delivered and she realized that both her and SF's phones had been disconnected.

BM notified her attorney SC had not yet been returned, and was advised to call LE. BM contacted LE via 911 at 4:37PM to report she did not know the whereabouts of SC. BM learned that there was a fire at the apartment complex where SF lived. She called 911 again at about 5:00PM. She went to the apartment complex of SF. Upon arrival, she learned the fire was in SF's unit and that his hunting rifle was missing. BM explained to an Arson Detective at the scene that SC was missing.

LE spoke with BM at the police barracks and gathered information to issue an Amber Alert for SC. LE made attempts to issue the alert, but were denied as the circumstance did not fit the criteria of the SC being abducted or believed to be in danger of serious bodily harm or death. At 7:30PM, it was learned SF's car crossed the George Washington Bridge hours earlier. A press release was scheduled for 12:00AM regarding the SC's unknown whereabouts.

At about 9:00AM on 06/07/18, BM returned to the police barracks and was told by LE that SF and SC were found deceased in another state. BM learned from the media that SF shot SC, turned the gun on himself, and the car was

smoldering when discovered. The missing hunting rifle was found inside the vehicle.

LE provided information to SCDSS that the car was found in a rural neighborhood about ¼ mile off Interstate 95. A 911 call was made at 7:50AM by a passerby who saw smoke coming from SF's vehicle. There was accelerant found in the vehicle, and the child was covered in soot. The child was found strapped in his car seat with a single gunshot wound to his head. The autopsy report showed that the SC's lungs did not contain smoke, determining that he was shot before the car was set on fire.

LE unsuccessfully searched for information as to why the SF was fleeing to another state. The SF conducted a master reset on his cell phone, and LE was unable to retrieve any data. They were unable to gather any additional information and were in the process of closing the criminal investigation. The case was determined a homicide/suicide.

During the investigation, SCDSS maintained detailed documentation of an interview with the BM, as well as numerous collateral contacts, including family members, LE, the ME, and the SC's pediatrician.

SCDSS offered services for identified needs to the BM and OA. The case was substantiated and closed in a timely manner.

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: Suffolk County does not have an OCFS Child Fatality Review Team at this time.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
046586 - Deceased Child, Male, 2 Yrs	046588 - Father, Male, 46 Year(s)	Inadequate Guardianship	Substantiated
046586 - Deceased Child, Male, 2 Yrs	046588 - Father, Male, 46 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?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
SCDSS gathered information from appropriate collateral contacts.

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 adult brother was offered mental health counseling; however, he was already engaged through an outside agency.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
BM was offered funeral assistance, bereavement and grief counseling, mental health counseling and assessed for alcohol abuse assistance. BM declined counseling services as she was obtaining them elsewhere.

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? Yes
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)
05/25/2018	Deceased Child, Male, 2 Years	Father, Male, 46 Years	Excessive Corporal Punishment	Unsubstantiated	Yes
	Deceased Child, Male, 2 Years	Father, Male, 46 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 2 Years	Father, Male, 46 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Male, 2 Years	Father, Male, 46 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Male, 2 Years	Mother, Female, 41 Years	Inadequate Guardianship	Unsubstantiated	

Deceased Child, Male, 2 Years	Mother, Female, 41 Years	Lacerations / Bruises / Welts	Unsubstantiated

Report Summary:
An SCR report received on 05/25/18 alleged the BM grabbed the SC with excessive force and the SC sustained bruises as a result. The report alleged BM left the stove's gas burner on, and the home reeked of gas while BM and SC were sleeping. A subsequent SCR report received on 06/05/18 alleged SF had been physically abusive toward SC for the past year. SF hit SC on the chest and as a result, SC stumbled backward. SF aggressively shook SC and grabbed his leg with excessive force and SC sustained finger mark bruising. SF used excessive force as a form of punishment. SF smoked marijuana while caring for SC and the drug and paraphernalia were accessible to the child.

Report Determination: Unfounded | **Date of Determination:** 07/23/2018

Basis for Determination:
SCDSS found that the SC turned the stove's gas burner on while the BM was not directly supervising him. SCDSS contacted collaterals and learned the SC was taken to his pediatrician and no medical attention was required due to the incident. The pediatrician noted that there was no suspected child abuse or maltreatment regarding the SC and could not verify if he had bruises that were caused by someone or caused maliciously. BM denied the SC was around drugs or had been physically injured at any time prior to the fatality.

OCFS Review Results:
SCDSS did not assess the safety of the child within 24 hours of receiving the initial report. There was not documentation of diligent attempts being made to assess the safety of the child immediately after the receipt of the SCR report; the child was not assessed for 5 days. The 7 day safety assessment was 4 days late.

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

Issue:
Timely/Adequate Seven Day Assessment
Summary:
The 7 day safety assessment was not completed until 4 days after the due date.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
The results of each safety assessment must be documented in the case record in the form and manner required by OCFS. In this instance, the required manner is by the completion of a 7-day safety assessment in Connections.

Issue:
Timely/Adequate 24 Hour Assessment
Summary:
SCDSS did not assess the safety of the SC within 24 hours after the receipt of the report.
Legal Reference:
SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:
SCDSS will adequately assess safety of children respective to case circumstances within 24 hours of each SCR report. SCDSS must conduct a face-to-face contact or a telephone contact with the subjects and/or other persons named in the report or other persons in a position to provide information about whether the child may be in immediate danger of serious harm.

[redacted]

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

There is no CPS history more than 3 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

Additional Local District Comments

"The SCR's acceptance of this fatality report established jurisdiction; Suffolk was compelled by law to investigate. Also there was an open investigation concerning family at the time of the reported fatality."

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