Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-19-049

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

Issue Date: Mar 16, 2020

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 17 year(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 10/01/2019
Initial Date OCFS Notified: 10/10/2019

Presenting Information

An SCR report alleged on 10/2/19, the adult sibling shot the 17-year-old male subject child possibly three times on the family's front lawn. The mother was present and witnessed the violence. The child was pronounced deceased at the residence. When the child was 16-years-old, the adult sibling became violent toward the child and an order of protection was issued protecting the child. The mother was aware of how violent the adult sibling could be and was aware of the danger to the child, yet she vacated the order of protection and allowed the child to be at further risk of being harmed by the adult sibling. The roles of the uncle and cousin who resided in the home were unknown.

Executive Summary

This fatality report concerns the death of the 17-year-old male subject child who died on 10/1/19 after he was shot by an adult sibling. The child resided with his mother. There were no minor surviving siblings or other children living in the home.

Suffolk County Department of Social Services (SCDSS) immediately notified law enforcement, who had already begun their investigation into the death. Law enforcement provided minimal information to SCDSS during their homicide investigation. Records that were provided noted the adult sibling was arrested for murder at the time of death.

During SCDSS's investigation, several home visits were made, and multiple family members were spoken to. The adult sibling had five children who were assessed to be safe with their mothers. Additionally, an 8-year-old nephew was present at the time of the fatal incident and he was assessed during the investigation.

On the evening of the fatal incident, the adult sibling was at his maternal uncle's home, where he resided for an unknown time. The aunt, 8-year-old cousin, mother and child were also present. The adult sibling was angry with the mother and was making nonsensical statements. The adult sibling was upset he was unable to see his children due to his apparent mental health conditions. The adult sibling stated that if he was not able to see his children, the mother would not be able to see her child either. It was reported he went outside and shot the subject child in the head. The child was pronounced dead at the scene.

An autopsy was performed; however, the medical examiner's office was not forthcoming with information. Law enforcement said the cause of death was multiple gunshot wounds to the head.

At the time of case closure, the outcome of the criminal investigation was ongoing. Law enforcement provided information indicating that the adult sibling had a significant criminal history, including unlawful possession of marijuana, criminal possession of a weapon, harassment and multiple accounts of endangering the welfare of a child. Furthermore, the documentation reflected the adult sibling had a domestic dispute with the child in 2018, when the adult sibling placed the child in a choke hold and bit him. The adult sibling was arrested for criminal obstruction of breathing and an order of protection was issued to protect the child.

The allegations in the report were unsubstantiated. The investigation revealed the adult sibling did not have caretaking responsibilities for the child, and the mother did not fail to protect the child. The record noted there was no action the mother could have taken to prevent the child's death.

The family was offered bereavement counseling and mental health referrals. Family members were accepting of the services and were engaged with support services within their church community.

PIP Requirement
For historical cases, SCDSS will submit a PIP to the Westchester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS will review the plan and revise as needed to address ongoing concerns.

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:
Safety Assessments and the Risk Assessment Profile were not required as there were no surviving children in the home.

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 case was appropriately determined and closed.

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: 10/01/2019 **Time of Death:** 05:50 PM

Time of fatal incident, if different than time of death: 05:42 PM

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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? No - Not needed given developmental age or circumstances

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	56 Year(s)
Other Household 1	Sibling	Alleged Perpetrator	Male	27 Year(s)

LDSS Response

On 10/10/19, SCDSS received the fatality report from the SCR and began their investigation. Within the first 24 hours of the investigation, SCDSS contacted the source of the report, documented a CPS history check and notified the ME and DA of the death. LE was contacted and records were requested.

On 10/10/19, the maternal uncle (MU) was interviewed as he and his 8-year-old son (OC), were listed on the SCR report; however, it was determined they were reported in error. The MU said on 10/2/19, the adult sibling (AS) went to the home of the MU. The AS was irate over family-related issues and threatened to kill the mother (SM). The MU said his wife intervened to deescalate the argument to no avail. The AS said he was going to kill everyone if LE was called, but the MU called 911. The AS said if he cannot see his children, the SM would not see hers either and then went outside. The AS leaned against the SM's car while the SC sat inside it. When LE arrived, the AS got into the car and shot the SC. The AS got out of the car and was taken into custody. The SC was not part of the family dispute. The MU expressed the AS's long criminal history and history of MH struggles. The OC was observed on this day to be safe with the MU.

On 10/15/19, the SM said the SC and AS had a good relationship except when the AS held the SC in a chokehold in 2018, and the AS was arrested. The SM said on 9/30/19, she pleaded with the AS to go to the hospital for his declining MH to no avail. The AS had delusions and hallucinated. The SM was too distraught to continue the interview.

On 10/15/19, the OC was interviewed. The OC knew the family was fighting but did not pay attention. He recalled the AS

said he was going out to his car and came back with a gun. The OC recognized the danger and went downstairs and did not come back until he heard loud bangs. He saw blood on the ground and the aunt told him what happened. He reported no concerns for his safety at home.

SCDSS contacted the mothers of the AS's children and other collaterals. It was learned the AS had a history of physical violence, repeatedly made death threats to many people, and had obvious untreated MH struggles. The mothers of the AS's children had orders of protection in the past due to his erratic behavior. The AS had limited contact with his children due to his behavior. The AS's children were assessed to be safe in the care of their mothers.

On 10/18/19, SCDSS visited the AS in jail. He was provided with written notice of the report and stated he did not have any questions. The record did not reflect an interview with the AS.

During the investigation, SCDSS received some records from LE, despite their initial unwillingness to cooperate with the CPS investigation. LE records noted on 7/9/18 an OP was issued against the AS regarding the SC and the AS's children. The OP was served on 9/4/18 and vacated on 9/5/18 as the SC refused to testify against the AS. On 10/1/19, LE responded to a domestic dispute at the MU's home. Records state the AS shot the SC in the head, resulting in his death. The AS was charged with murder that day and was arraigned on 10/11/19. LE records noted the ME listed the cause of death was multiple gunshot wounds to the head. The AS was remanded without bail and remained incarcerated at the time of case closure.

SCDSS determined their investigation and closed the case on 11/21/19. The investigation did not reveal credible evidence to support the SC was placed at risk of harm by the SM's actions or inactions, and the AS was not determined to be a person legally responsible for the SC. The SM, MU, aunt and OC were offered an abundance of services including MH counseling referrals and bereavement services. The family was accepting of the services, and some family members began their counseling at the time of case closure.

Official Manner and Cause of Death

Official Manner: Unknown
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: Although SCDSS attempted to obtain records from law enforcement, other first responders, and the medical examiner, they were not forthcoming with all information relating to the death.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Suffolk County does not have an OCFS-approved Child Fatality Review Team at this time.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053433 - Deceased Child, Male, 17 Yrs	053435 - Sibling, Male, 27 Year(s)	DOA / Fatality	Unsubstantiated
053433 - Deceased Child, Male, 17 Yrs	053435 - Sibling, Male, 27 Year(s)	Inadequate Guardianship	Unsubstantiated

053433 - Deceased Child, Male, 17 Yrs	053435 - Sibling, Male, 27 Year(s)	Internal Injuries	Unsubstantiated
053433 - Deceased Child, Male, 17 Yrs	053434 - Mother, Female, 56 Year(s)	DOA / Fatality	Unsubstantiated
053433 - Deceased Child, Male, 17 Yrs	053434 - Mother, Female, 56 Year(s)	Inadequate Guardianship	Unsubstantiated

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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 attempted to collaborate investigative efforts with the MDT; however, LE and the ME were not forthcoming with information due to the ongoing criminal case. The record did not reflect the adult sibling was 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?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 1

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Pending	The adult sibling	Pending	Remanded without bail
Comments:	On 10/1/19, the adult sibling was arrested for murder, a class A felony. He was remanded on 10/4/19. The case was adjourned on 10/8/19. On 10/11/19, the adult sibling was arraigned and pled not guilty to the charge. He was ordered to a psychiatric exam. The criminal court proceedings were ongoing at the time of this writing.		

Criminal Charge: Other - Criminal Possession of a Loaded Firearm	**Degree:** 3		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	The adult sibling	Pending	Remanded without bail
Comments:	On 10/8/19, the adult sibling was charged with criminal possession of a loaded firearm, a class C felony.		

Criminal Charge: Other - Criminal Possession of a Weapon in the 3rd degree.	**Degree:** 1		
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Pending	The adult sibling	Pending	Remanded without bail
Comments:	On 10/8/19, the adult sibling was charged with Criminal Possession of a Weapon in the 3rd degree, a class D felony with a previous conviction.		

Have any Orders of Protection been issued? No

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:
SCDSS offered appropriate services to the family as well as others who were involved with the adult sibling, including the mother of his children. The adult sibling had limited contact with his children.

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 other children residing in the household; however, a minor cousin who was at the residence at the time of the fatal incident, was offered services and was engaged with a mental health counselor through his school at the time of case closure. Additionally, he was receiving support from a local church organization.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was offered and accepted services in response to the fatality including bereavement services. The aunt and uncle were also offered services as they were witness to the fatal event.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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? N/A
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)

07/09/2018	Other Child - 6yo niece, Female, 6 Years	Sibling, Male, 26 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 16 Years	Sibling, Male, 26 Years	Choking / Twisting / Shaking	Unsubstantiated	
	Deceased Child, Male, 16 Years	Sibling, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Male, 16 Years	Mother, Female, 53 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Nephew, Male, 1 Years	Sibling, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - 1yo niece, Female, 1 Years	Sibling, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - 6yo cousin, Male, 6 Years	Sibling, Male, 26 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report alleged the mother was aware that the adult sibling had an extensive history of violence and aggression toward family members and others. The mother failed to intervene to protect the child. As a result, on 7/8/18, the adult sibling choked the child and threw items around the house while other children ages 1, 2, and 6 years were present. The children were not injured. The role of the 2-year-old's mother was unknown.

Report Determination: Indicated | **Date of Determination:** 10/31/2018

Basis for Determination:
SCDSS found credible evidence to support the allegation of IG against the adult sibling regarding his 6-year-old child, niece to the subject child. The niece witnessed the violence and was fearful of the adult sibling. There was no credible evidence to support the allegations of IG, C/T/S against the mother or the allegations of IG and C/T/S regarding the children as he did not have caretaking responsibilities for the children.

OCFS Review Results:
SCDSS initiated the investigation timely, contacted the source of the report and completed the Safety Assessments accurately; however, the 7-day Safety Assessment was not approved timely. The CPS history check was documented timely and the Risk Assessment Profile was completed accurately. Written notice of the report was not provided to all adults and parents of children on the report and written notice of indication letters were provided to all adults on the report. Interviews were documented to be allegation focused and did not reflect an overall assessment of safety and risk. One of the adult siblings of the child, who resided in the home, was not documented to have been interviewed.

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

Issue:
Failure to provide notice of report

Summary:
Although written notice of the report was provided to the mother, adult sibling and the mother to one of his children timely, there was no documentation notices of existence were provided to the other adults/parents on the report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
SCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Issue:
Timely/Adequate Seven Day Assessment

Summary:
Although the 7-day Safety Assessment was documented timely, it was not approved by supervision timely. The Safety Assessment was approved on 8/17/18.
Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:
SCDSS will document assessment of safety and risk of all children in the household within the required timeframe of 7 days.

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:
Although many family members declined to be interviewed and CPS appropriately documented such, the interviews that were documented with the adults and children on the report appeared to be allegation focused and lacked documentation that overall safety and risk was assessed for the children.
Legal Reference:
432.1 (o)
Action:
SCDSS will make casework contacts in accordance with the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

[redacted]

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

There is 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 New York.

Preventive Services History

There was no Preventive History that was relevant to the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☐ Family Court ☐ Criminal Court ☒ Order of Protection

Have any Orders of Protection been issued? Yes	
From: 07/09/2018	**To:** 09/04/2018

Explain:
After a domestic violence incident, an Order of Protection was granted for a full stay-away order against the adult sibling, in protection of his children and the subject child. The order was served on 9/4/18 and disposed of on 9/5/18.

Additional Local District Comments

The CPS investigation which was cited for correction was from 2018. The 2019 PIP, which is still active, addressed the issue of late 7-Day Safety Assessments. The number of timely 7-Day Safety Assessments has increased to 77%, just 2 percentage points below the state median of 79% according to the most recent NYS OCFS Performance Report. Likewise, the issue of providing notice of the report was also addressed in the prior PIP, and monitoring continues to be ongoing concerning this issue. Additionally, although documentation of interviews appeared to be "allegation focused" it is apparent that the interviews yielded enough pertinent information to make an appropriate determination, as OCFS has not taken issue with the investigation conclusion.

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