Child Fatality Report

Report Identification Number: SY-23-004

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

Issue Date: Jun 27, 2023

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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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: 14 year(s)
Jurisdiction: Onondaga
Gender: Female
Date of Death: 01/20/2023
Initial Date OCFS Notified: 01/20/2023

Presenting Information

The SCR report alleged that on 1/20/23, at an unknown time before 8:00AM, the father shot the subject child in the back with a shotgun. The subject child sustained a large gunshot wound to her back, which resulted in her death. The subject child was found face-down and deceased on her bed in her bedroom. The father shot himself with the shotgun and died. The role of the mother was unknown.

Executive Summary

This fatality report concerns the death of the 14-year-old female subject child that occurred on 1/20/23. The SCR report contained allegations of Inadequate Guardianship, Internal Injuries, and DOA/Fatality against the father. At the time of her death, the subject child resided with her father. The mother resided in a separate residence nearby that the subject child visited regularly.

Onondaga County Department of Children and Family Services (OCDCFS) completed casework and collateral contacts and learned that on 1/20/23, while at his residence, the father shot the subject child in the back with a shotgun. The subject child was found on her bed in her bedroom. After shooting the subject child, the father shot and killed himself. The father was located on the floor of a separate bedroom. The subject child and father were pronounced deceased at the father's residence.

An autopsy was performed, and the final cause of death was listed as two gunshot wounds of the back. The manner of death was homicide. The criminal investigation remained open at the time the CPS investigation was closed.

Bereavement services were offered to the mother; however, it was unknown if the mother utilized the services. The allegations against the father were substantiated, as the father fatally shot the subject child, resulting in her death. There were no surviving siblings. The CPS investigation was indicated and closed on 3/14/23.

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:
OCDCFS made an appropriate determination based on evidence gathered throughout their investigation.

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? No

Explain:
Casework activity was commensurate with case circumstances.

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: 01/20/2023 **Time of Death:** Unknown

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Unknown
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☒ Unknown
☐ Other

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	Female	14 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	51 Year(s)

Other Household 1	Mother	No Role	Female	44 Year(s)

LDSS Response

Upon receipt of the SCR report, OCDCFS interviewed the mother, completed a CPS history check, and contacted collateral sources.

OCDCFS interviewed the mother about the events preceding the subject child's death. The mother reported that on 1/19/23, the SC stayed late at school. The mother offered to pick the SC up from school, but the father stated he would. The mother facetimed with the SC on the evening of 1/19/23 and stated everything appeared to be normal with the SC. Between 9:30PM and 10:00PM on 1/19/23, the SC texted the mother stating the father was trying to find out where the mother was and advised the mother to turn off her location if it was on. The father began texting the mother and accusing her of ditching the SC for another male. The father continued to text and attempted to facetime the mother. The mother finally spoke to the father via phone and recorded the call. The details of this phone call were unknown to this writer. The phone call ended, and the father continued to text the mother. The last text from the father was around 12:00AM on 1/20/23 and the message contained a photo of the father and SC holding hands. Around 8:00AM on 1/20/23, the mother received a phone call from the SC's school stating she was absent. The mother felt this was strange since the father or SC would usually make her aware if the SC stayed home from school. The mother attempted to call the father and SC to no avail. The mother called a MU and PGM on her way to the father's residence. When the mother arrived at the residence, she observed the father's car in the driveway. The mother knocked but there was no answer. The mother had a key to the house but had a bad feeling and did not want to enter the house. The mother called 911 and LE responded. The mother provided LE with the key and LE entered the home. LE located the SC deceased in her bed from two gunshot wounds to the back and the father deceased in a separate room with a gunshot wound. The shotgun was in the room with the father. The SC and father were pronounced deceased at the residence.

The mother and father had been separated for two years, after the father kicked the mother out of the residence. The SC primarily resided with the father, as that residence had always been her home. The father had a history of unknown mental health diagnoses, was previously engaged in mental health treatment, and on unknown medication to treat such diagnoses. The mother reported the father struggled with his mental health after their separation and was regularly speaking to a therapist as a result.

The mother reported receiving texts from an unknown number that she assumed to be the father. The father reported to the mother prior to the fatal incident that he was also receiving text messages from an unknown number asking him about a guy the mother was seeing. Two days before the SC's death, the mother contacted LE and reported the text messages. A MA who was present during the mother's interview reported the father showed up to the mother's house while LE were present and LE spoke to the father. The text messages to the mother stopped after this. The mother stated she began a new relationship, and the father was obsessive about it. The father consistently tried to get information from the mother about where she was and who she was with.

The mother denied the father was ever physically violent toward herself or the SC. The mother denied knowledge that the father owned a firearm and stated she was shocked when she learned this. The mother and MA stated the SC never reported anything that would have led the mother to believe the SC was unsafe in the care of the father. The SC's school counselor stated the SC appeared to have a positive relationship with both of her parents, and there were no noted concerns.

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 referred to an OCFS approved Child Fatality Review Team? Yes
Comments: Onondaga County referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064011 - Deceased Child, Female, 14 Yrs	064012 - Father, Male, 51 Year(s)	DOA / Fatality	Substantiated
064011 - Deceased Child, Female, 14 Yrs	064012 - Father, Male, 51 Year(s)	Inadequate Guardianship	Substantiated
064011 - Deceased Child, Female, 14 Yrs	064012 - Father, Male, 51 Year(s)	Internal Injuries	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:
The SF and SC were deceased and unable to be interviewed regarding the circumstances surrounding the fatality. The BM called a PGM to meet at the SF's home after learning the SC was absent; however, the record did not reflect the PGM was contacted.

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	☒	☐	☐	☐	☐	☐	☐

Other, specify: Victim Advocate

Additional information, if necessary:
OCDCFS offered bereavement services and funeral assistance to the mother; however, it was unknown if these services were utilized. A victim advocate was present during the mother's face-to-face interview to provide additional support.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Bereavement services were offered to the mother; however, it was unknown if she was engaged in grief counseling at the time the CPS investigation closed. OCDCFS utilized a victim advocate to provide additional support during their face-to-face visit with the mother.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child acutely ill during the two weeks before death? No

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 - Investigative History More Than Three Years Prior to the Fatality

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known history outside of New York State.

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