Child Fatality Report

Report Identification Number: RO-25-001

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

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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: 11 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 01/03/2025
Initial Date OCFS Notified: 01/03/2025

Presenting Information

An SCR report was received that alleged on 1/3/25, around 12:00PM, the father shot the grandmother, the 11-year-old subject child, and then shot himself. The subject child was struck twice on her chest, her left shoulder, the back of her neck, and on her left calf. The subject child was wrapped in a fabric by a neighbor and her body was located outside the home. The other adult contacted 911 and emergency medical services (EMS) arrived at the home shortly after. When EMS arrived, they performed cardiopulmonary resuscitation (CPR) on the subject child. The subject child was transported to the hospital by ambulance, she was given three doses of epinephrine and CPR continued. The subject child arrived at the hospital at 12:18PM and she was intubated. The subject child was pronounced deceased at 12:29PM. The grandmother was also deceased. The mother was in Canada at the time of the subject child's death.

Executive Summary

This report concerns the death of the 11-year-old female subject child. The Monroe County Department of Human Services received an SCR report regarding the child's death on 1/3/25. The SCR report was received on the same day that the subject father murdered the maternal grandmother and subject child and subsequently killed himself. At the time of the subject child's death, she resided with her mother. There were no surviving siblings.

Monroe County Department of Human Services learned that on 1/3/25, the subject father entered the mother's residence and shot the subject child, maternal grandmother and then shot himself. The mother was out of town at the time of the incident. After killing the subject child, the subject father brought her body outside and placed her on a neighbor's porch where she was observed by a person walking by the residence; 911 was called immediately. The subject father went back to the mother's residence where he shot himself and was found dead. It was believed that the subject father may have been experiencing some mental health issues days prior to the murders, as he stole guns from his father. EMS transported the subject child to hospital via ambulance. They administered CPR until they arrived at the hospital. Hospital staff took over and continued to administer life-saving measures to no avail. The SC was pronounced deceased on 01/03/25 at 12:29PM.

The Monroe County Department of Human Services coordinated investigative efforts with law enforcement. Law enforcement utilized the camera footage from the home to review and put together a timeline of events leading up to the murders. Law enforcement closed their investigation after determining the incident was a murder/suicide. An autopsy was performed; however, the autopsy report was not yet available at the time of this writing. The medical examiner reported that the preliminary autopsy listed the immediate cause of death was a result of multiple gunshot wounds. The manner of death was reported as a homicide.

MCDHS interviewed the biological mother who reported she was out of the country when the incident occurred. She had no information to provide regarding the events that occurred on the day of her daughter's death. She reported that overall, the subject father was a good father, and she had no concerns. She reported that he never threatened to harm the family. She denied having any previous indication he would ever take such violent actions.

The allegations of Inadequate Guardianship, Internal injuries and DOA/Fatality were substantiated. There was a fair preponderance of evidence that the child was placed at imminent risk of physical, mental and emotional impairment

which led to her death. Furthermore, information gathered from the medical examiner's office confirmed the child died from multiple gunshot wounds that were inflicted by her father.

Law Enforcement provided the mother with a cleaning service to assist with cleaning the crime scene. The mother had also been linked with Crime Victim Services. The mother reported having a strong support system with family and friends helping her deal with this tragedy.

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:
Casework activity was commensurate with case circumstances.

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:
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

Child Fatality Report

Date of Death: 01/03/2025 **Time of Death:** 12:29 PM

Time of fatal incident, if different than time of death: 12:00 PM

County where fatality incident occurred: Monroe
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 and/or ingested alcohol or drugs? Unknown
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: 2

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	11 Year(s)
Deceased Child's Household	Mother	No Role	Female	42 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	53 Year(s)
Other Household 2	Grandparent	No Role	Female	74 Year(s)

LDSS Response

On 1/3/25 at 12:00PM, MCDHS received a report regarding the death of the (SC). MCDHS initiated their investigation within 24 hours, contacted the source of the report, coordinated with LE, completed a history check which revealed no prior CPS history, and informed the DA of the fatality. There were no surviving siblings.

On 1/3/25, the SC was in the care of her MGM in the home she shares with the BM when the SF gained entry to the residence and murdered both the MGM and SC. The BM was out of the country at the time of the child's death.

It was reported that the day before the murder, on 1/2/25, 911 was called to the home when the SF arrived at the residence and demanded he be allowed to take the SC with him. The MGM would not allow him to take the child as the SC was clear that it was not her wish to go with her father. When LE responded to the home, they asked the SF to leave the residence as they were unaware of the legalities of the custody agreement between the SF and BM regarding the child. The SF left the residence stating he was going to Family Court. It was unknown if the SF filed in family court or if there was a pre-existing custody order. The SF and BM had been divorced for over ten years. On 1/2/25, it was believed that the SF

was angry that the BM was on a trip with her boyfriend, and according to LE this could have been a contributing factor which triggered the SF's behavior the following day.

On 01/03/25, the SF parked his car around the corner from the SC's family home. The SF entered the home with a gun, killing the MGM first and then he shot the SC multiple times. After killing the SC, the SF picked her up and carried her outside and placed her on a neighbor's porch. The SF returned to the home of the SC and shot himself where he succumbed to his injuries. A neighbor walking by noticed the SC on the porch and called 911. EMS transported the SC to the hospital via ambulance where they administered CPR until reaching the hospital.

Medical records were received on 01/03/25. It was reported that the SC had suffered multiple gunshot wounds to the back of her head, left calf, right shoulder, the right side of her chest and her right arm. She was asystole upon arrival to the ER. Life-saving measures were administered to no avail. The SC was pronounced deceased on 01/03/25 at 12:29PM.

The BM was interviewed via phone on 2/19/25. She reported she would never imagine that the SF was capable of this crime. There was a domestic violence incident between her and the SF when the SC was two years of age. The incident ended their marriage. She stated that the domestic violence incident was isolated, it never happened again. She denied that the SF threatened her or the SC over the years. She stated the SF did have a drinking problem, but he would self-isolate when drinking and he wouldn't come around the SC. Over the summer, she went as far as thanking him for setting healthy boundaries when he drinks and not exposing the SC to his drinking. She did report that earlier in the week the SF was angry, but she just thought he would go to family court and make a complaint. She denied that she had any concerns regarding the SF. She stated that they did have a visitation agreement, but the SF didn't follow it. She stated she always honored the custody agreement and allowed him to see the SC when he was healthy. She reported that she shared custody of the SC with the SF. She had primary residency of the SC.

MCDHS and law enforcement offered the mother fatality related services The CPS investigation was closed timely on 2/24/25.

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes
Comments: MCDHS referred this case to their local Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
069902 - Deceased Child, Female, 11 Year(s)	069904 - Father, Male, 53 Year(s)	DOA / Fatality	Substantiated

069902 - Deceased Child, Female, 11 Year(s)	069904 - Father, Male, 53 Year(s)	Inadequate Guardianship	Substantiated
069902 - Deceased Child, Female, 11 Year(s)	069904 - Father, Male, 53 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?	☐	☒	☐	☐
Family Members	☐	☐	☐	☒
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 mother was interviewed via phone due to the nature of this case and where the child died.

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 at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? No
Explain:
There were no surviving siblings. The SC was an only child.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
Bereavement services were offered to the mother; however, she was receiving services though the crimes victim's unit.

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 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