Child Fatality Report

Report Identification Number: NY-23-077

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

Issue Date: Jan 22, 2024

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: 9 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 08/17/2023
Initial Date OCFS Notified: 08/17/2023

Presenting Information

An SCR report alleged that the 9-year-old subject child had a developmental disorder, was nonverbal, and had a history of wandering off. The child required a higher level of supervision. On 8/16/23 at approximately 8:15 PM, the mother went to the store with the child and her other children. While the mother shopped, she left the child in the children's play area without supervision. Sometime before 9:00 PM, the mother noticed the child was not in the play area and was missing. An unknown individual called 911 and reported the incident. At approximately 12:00 AM, the child's body was recovered from a nearby water canal. The child was pronounced deceased on 8/17/23 at 1:16 AM. The report alleged that the mother's lack of supervision contributed to the child's death.

Executive Summary

This fatality report is regarding the death of a 9-year-old male child that occurred on 8/17/23. An SCR report was made on the same day and included allegations of Inadequate Guardianship, Lack of Supervision, and DOA/Fatality against the mother. At the time of his death, the child resided with his parents, paternal grandparents, maternal grandmother, and three siblings ages 15, 7 and 3 years old. The surviving children were determined to be safe in the care of their parents.

The Administration for Children's Services (ACS) coordinated investigative efforts with law enforcement. It was learned that the subject child was diagnosed with a developmental disorder when he was 3 years old and he was nonverbal. The child had a history of absconding from the home and the supervision of adults while in the community. The family had previous involvement with ACS due to these concerns and were referred to an advocates preventive-only services case in 2020. The family had a home health aide and services through the Office for People With Developmental Disabilities (OPWDD). The aide was in the home Monday through Friday 3:00 PM through 10:00 PM and on Saturdays 11:00 AM through 8:00 PM, and assisted with the supervision of the child.

On the evening of 8/16/23, the mother, two younger siblings, child, and aide went to the store. The children were jumping on mattresses and playing. The mother instructed the aide to release the child's hand to allow him to engage in the play. The mother and aide had a brief conversation, and the child left the area and got onto an escalator leading out to the parking lot. The family and aide noticed the child was missing and contacted law enforcement. After several hours of searching, the child's body was discovered in a water canal next to the store. First responders attempted life-saving measures while transporting the child to the hospital; however, the child was dead on arrival at the emergency room and was pronounced deceased on 8/17/23 at 1:16 AM.

The family declined an internal autopsy due to their religious beliefs. Since there was no evidence of harm to the child or concerns about drug use, one was not performed. The Medical Examiner completed an external review, including x-rays, and the child was not found to have any injuries. The child was determined to be of normal physical development. The Medical Examiner learned from the family that the child was fascinated by water but did not know how to swim. The Medical Examiner explained that children with the child's developmental disorder were drawn to water; therefore, there were several deaths whereby they wandered off and drowned. Based on the examination of the child and the information gathered, the cause of death was determined to be drowning and the manner was accidental. Law enforcement investigated the fatality and determined no criminality concerning the death.

ACS offered services to the parents, siblings, and grandparents. The mother initially enrolled in grief counseling services but later stopped, and preventive services were assisting the mother with locating a provider in her primary language. No

other family members were enrolled in grief counseling at the time of case closure and funeral assistance was declined.

ACS substantiated the allegation of Lack of Supervision against the mother. It was determined the aide was holding the child's hand before the incident, and the mother told her it was okay to let it go. Shortly after, the child absconded from the area while unsupervised. ACS unsubstantiated Inadequate Guardianship and supported their determination by stating that the mother ensured the child's medical, educational, and basic needs were met and service providers did not have any concerns for the family. ACS unsubstantiated DOA/Fatality and supported the determination with the autopsy results and law enforcement's investigation revealing no criminality. The investigation was indicated and closed on 10/16/23.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS 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:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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?** No

Explain:
Although sufficient information regarding the allegations was gathered during the investigation, an incorrect determination was made in regard to DOA/Fatality.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Following the death, the adovcates preventive-only case was converted to a preventive services case to provide for fatality-related services for the family.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	Due to the child's developmental disorder and history of running away, he required constant supervision. While unsupervised at the store, the child gained access to the water canal and drowned. Despite this, DOA/Fatality was unsubstantiated.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the New York City Regional Office if further guidance is needed.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	The 30-day Safety Assessment tool was not completed in Connections.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must complete a safety assessment at 30 days for reports of a child fatality unless there are no surviving siblings or children in the household. This is in addition to the 24-hour assessment, the initial seven-day assessment and the conclusion safety assessment
Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Fatality Report was completed late in Connections on 10/16/23.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	The 30-day Fatality Report must be documented in a template in Connections within 30 days of the receipt of a report alleging the death of a child because of abuse or maltreatment.
Issue:	Mandated reporters did not report potential abuse or maltreatment of a child
Summary:	ACS discovered that the home health aide was responsible for the supervision of the SC at the time of his death and failed to provide the required level of supervision when the SC absconded and drowned. ACS did not report this information to the SCR.
Legal Reference:	SSL 413 and 415
Action:	Mandated reporters are required to report or cause a report to be made when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/17/2023 **Time of Death:** 01:16 AM

Date of fatal incident, if different than date of death: 08/16/2023
Time of fatal incident, if different than time of death: 09:00 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 08:00 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
Child's activity at time of incident:

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

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 on Report	Alleged Victim	Male	9 Year(s)
Deceased Child's Household	Father	No Role	Male	40 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	71 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	67 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	60 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)

LDSS Response

Upon receipt of the SCR report on 8/17/23, ACS coordinated efforts with law enforcement, sent notification to the Medical Examiner and District Attorney, interviewed the family, gathered information from collaterals, and assessed the safety of the surviving children.

ACS interviewed the mother who reported that on 8/16/23, she was at home spending time with the children. The father was traveling outside of the country. The 7yo sibling asked if they could go to the store to buy toys and the mother agreed. After they were finished, the mother wanted to do something for the subject child as well. The mother, two younger siblings, and home health aide went to a different store. The children began playing and jumping on the display beds. The aide was holding the child's hand, and the mother told the aide she could let go of him and just watch him while he jumped. The mother and aide then engaged in a conversation about a bed the aide was suggesting the mother buy for the child. During that time, the child went missing. The mother reported they had been in the store for only 7 minutes before this happened. The mother began looking through the store and then asked store staff to check their video cameras for the child, but they refused. After 20 minutes, the mother called law enforcement. Law enforcement checked the video footage and saw that the child left the store. Around 9:10 PM, the child's shoe was located near the shoreline of the canal. The

mother reported the child's body was located on 8/17/23 at 12:00 AM.

ACS completed home visits and assessed the safety of the surviving siblings. The 15yo sibling confirmed a history of the child absconding from the home; however, stated it had not occurred in the recent months due to additional locks on the door of the home. The 15yo sibling was not with the family at the store when the child went missing. Though present, the 7yo sibling did not add any additional information regarding the fatal incident, nor did she disclose any safety concerns. The 3yo sibling was unable to engage with the interview, but her safety was otherwise assessed.

ACS gathered information from law enforcement regarding the fatal incident. Law enforcement responded to the scene regarding the child missing and watched the store's video footage. At 8:15 PM, the family was observed getting on the escalator and the home health aide was holding the child's hand. The family disappeared from the video and then the child was seen at 8:20 PM alone entering the freight elevator. The child got out of the freight elevator, roamed the floor, and then he went by the cash registers where he appeared to be looking for his family. At 8:22 PM, the child was observed going down the stairwell and then the child was seen at 8:24 PM in the indoor parking lot walking towards the outside parking lot. At 8:26 PM, the child was observed walking towards the shoreline until he was out of the video frame.

ACS spoke to the family’s advocates preventive worker, who confirmed they opened services for the family in 2020. Monthly virtual visits were provided, and the family was assisted in obtaining services through OPWDD and a home health aide. The child’s care manager had no concerns about the supervision of the child, as during a planning meeting the mother reported the child had constant 1 on 1 supervision. ACS attempted to speak with the home health aide, but the aide and the agency did not return ACS’ calls. Collaterals including the pediatrician, school, and neighbors, expressed no safety concerns for the family.

Official Manner and Cause of Death

Official Manner: Accident
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?No
Comments: New York City does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065708 - Deceased Child on Report, Male, 9 Year(s)	065709 - Mother, Female, 35 Year(s)	DOA / Fatality	Unsubstantiated
065708 - Deceased Child on Report, Male, 9 Year(s)	065709 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Unsubstantiated
065708 - Deceased Child on Report, Male, 9 Year(s)	065709 - Mother, Female, 35 Year(s)	Lack of Supervision	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:

ACS attempted to interview the grandparents face-to-face and were only able to interview the MGM via telephone. ACS attempted contact with the home health aide agency; however, they did not return ACS' calls.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to

				Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

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? Unable to Determine
Explain:
ACS offered the siblings services in relation to the child's death; however, they were declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was in receipt of grief counseling services; however, wished to obtain a service provider who spoke her primary language, and preventive services were assisting with this. The father declined bereavement services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)	Status/Outcome	Compliance Issue(s)
03/13/2023	Deceased Child, Male, 9 Years	Mother, Female, 35 Years	Inadequate Guardianship	Far-Open	No
	Deceased Child, Male, 9 Years	Mother, Female, 35 Years	Lack of Supervision	Far-Open	
	Deceased Child, Male, 9 Years	Father, Male, 40 Years	Inadequate Guardianship	Far-Open	
	Deceased Child, Male, 9 Years	Father, Male, 40 Years	Lack of Supervision	Far-Open	

Report Summary:
An SCR report alleged that the subject child had a developmental disorder and required a higher level of supervision. On 3/14/23, the mother and father were acting as the caretakers of the child when he left the home unannounced. The child traveled away from the home and the parents were unaware of his whereabouts. The child had a history of leaving the

home and the parents failed to provide a higher level of supervision for him.

OCFS Review Results:
ACS appropriately tracked the SCR report as FAR and completed FAR activities with the family. ACS attempted to engage with all family members during the FAR case. The family had advocates preventive-only services and a home health aide to assist with the SC's absconding behaviors. The attendant was caring for the SC when he fled the home. Following the incident, the family installed another lock on the door and a door handle cover. The family was cooperative with all service providers in addressing the SC's needs. The SC ran from the PGF during the FAR case and was hit by a car. The SC was medically cleared and the SM agreed to not allow the grandparents to supervise the SC.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
09/21/2020	Deceased Child, Male, 6 Years	Grandparent, Male, 68 Years	Inadequate Guardianship	Far-Open	No
	Deceased Child, Male, 6 Years	Grandparent, Male, 68 Years	Lack of Supervision	Far-Open	

Report Summary:
An SCR report alleged that on 9/18/20, the grandfather failed to adequately supervise the subject child. The subject child was found outside in the community alone and unsupervised. The child did not sustain any known injuries.

OCFS Review Results:
ACS completed several home visits, explained FAR, and completed FAR activities. Concerns regarding the subject child absconding from the home while unsupervised were identified and services were offered to assist the family. Safe sleep was not being practiced with the youngest sibling, and ACS educated the parents on safe sleep guidance and provided them with safe sleep provisions. ACS spoke to the school, neighbors, pediatrician, and neurologist regarding the family and inquired on how to best support them. The family was connected with community-based agencies and ACS opened an advocates preventive-only services case. The parents were cooperative and accepted referrals for services.

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

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

In 2017, the father had an indicated CPS investigation regarding the subject child. The father was substantiated for Inadequate Guardianship and Excessive Corporal Punishment after he hit the child in his face. ACS filed a neglect petition against the father and a services case was opened.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open preventive services case at the time of the fatality? Yes
Date the preventive services case was opened: 10/01/2020

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content	☐	☐	☒	☐

requirements for progress notes?				
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
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?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☐	☐	☒	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☐	☐	☒	☐

Provider

	Yes	No	N/A	Unable to Determine
Were Services provided by a provider other than the Local Department of Social Services?	☒	☐	☐	☐

Additional information, if necessary:
The family received services through an Advocates Preventive-Only (ADVPO) Case. For these case types, the records are not required to be maintained electronically, and information regarding casework activity was gathered from assessments completed following the child's death.

Preventive Services History

The family received preventive service in 2017 following the neglect petition filed by ACS. The BF completed the required services including anger management and parenting classes. The children were determined to be safe and their needs were being met. The family court petition was dismissed and the case was closed.

In 2020, the family was referred to ADVPO services due to concerns about the supervision of the SC. The family obtained additional locks on their door to assist with the SC absconding from their home. The family was connected with services through OPWDD and a home health aide. In January 2023, the SC ran from the home and was found by LE. In March 2023, the SC ran from the home and was found at a nearby store. In April 2023, the SC ran from the PGF while at the park and was hit by a car. After the incident in January 2023, the contracted agency requested an elevated-risk conference with ACS. It was determined the parents would utilize a top lock for the door so the SC could not reach it and continue to use the home health aide as a support in supervising the SC. A supervision plan was developed in which the SC was to be supervised at all times and the PGF was unable to supervise. The advocates preventive-only case ended on 8/2/23 and the family was receiving services through community agencies. The case had not yet been closed in CONNECTIONS.

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