Child Fatality Report

Report Identification Number: SV-23-026

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

Issue Date: Oct 31, 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 **Jurisdiction:** Westchester **Date of Death:** 05/25/2023
Age: 10 year(s) **Gender:** Male **Initial Date OCFS Notified:** 05/26/2023

Presenting Information

Westchester County Department of Social Services (WCDSS) received an SCR report which alleged on 5/25/2023, the 10-year-old subject child was unsupervised and hung himself on a fence in his backyard. The subject child was alleged to have had significant mental health and behavioral issues including multiple diagnoses.

Executive Summary

On 5/25/2023 WCDSS received an SCR report regarding the death of the 10-year-old male subject child that occurred on 5/25/2023. At the time of his death, the subject child's family had an open preventive services case due to domestic violence and marital issues impacting the subject child's mental health. A subsequent CPS report was received on 5/26/2023 containing allegations of Educational Neglect, DOA/Fatality, Inadequate Guardianship, Lack of Medical Care, and Lack of Supervision against both parents. There were also allegations of DOA/Fatality, Inadequate Guardianship, Lack of Medical Care, and Lack of Supervision against the paternal grandfather. The child resided with his parents, paternal grandfather, and the father's paramour in one home. There were adult surviving siblings.

WCDSS collaborated investigative efforts with law enforcement and learned on 5/25/2023, the subject child was in the care of his father after the mother left for work. The father was to take the child to his mental health appointment that day at an unknown time. The record reflected the father was unable to take the subject child for his mental health appointment because his employer did not approve the time. The father had a scheduled haircut appointment that evening at approximately 7:00PM and asked the child if he wanted to attend with him. The subject child elected to stay home with the paternal grandfather. A short time later, while at the barber shop, the father received a phone call from the paternal grandfather stating that the subject child was dead. The father went to the home and found the paternal grandfather standing next to the subject child who was hanging from the backyard fence with a measuring tape wrapped around his neck and unresponsive. The grandfather was unable to remove the subject child from the fence due to his weight. The father got the child off the fence and then proceeded to call 911. Emergency medical services responded and attempted CPR for approximately 20 minutes without success. The child was transported to the hospital where he was pronounced deceased.

An autopsy was performed, and the medical examiner reported that the cause of death was asphyxiation due to ligature around the neck and ruled the death, accidental, undetermined or suicide. The child had significant mental health and was struggling with his parents unsettled and volatile relationship in which he appeared to be caught in the middle of. The child had displayed no signs of suicidal ideations or abnormal behaviors the days or hours leading up to his death. There was no suicide note left.

WCDSS substantiated the allegations of Inadequate Guardianship and Lack of Medical care against the paternal grandfather for calling the father and waiting for the father to come home instead of 911 when he found the subject child hanging on the fence. WCDSS determined that there was no evidence to support the other allegations and they were all unsubstantiated. The CPS investigation was closed and indicated on 7/25/2023. WCDSS offered the family bereavement and mental health services.

PIP Requirement

WCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify actions the WCDSS has taken, or will take, to address the cited issues. For issues where a PIP is currently

implemented, WCDSS 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:
The determination was made in congruence with the evidence gathered.

Was the decision to close the case appropriate? Yes

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:
Casework activity was not commensurate with case circumstances. The father's paramour who lived in the home and had consistent contact with the SC was never interviewed.

Required Actions Related to the Fatality

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

Issue:	Adequacy of face-to-face contacts with the child and/or child's parents or guardians
Summary:	WCDSS did not interview the SF’s paramour who had an active role in the case and resided in the home.
Legal Reference:	18 NYCRR 432.1 (o)
Action:	WCDSS will make efforts to make face-to-face contact with a child and/or a child’s parents or guardians and document efforts that were unsuccessful.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/25/2023 **Time of Death:** 08:48 PM

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

County where fatality incident occurred: Westchester
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: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	10 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	40 Year(s)
Deceased Child's Household	Father's Partner	No Role	Female	34 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Male	69 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)

LDSS Response

Upon receipt of the SCR report on 5/25/2023, WCDSS initiated their response within the 24 hours and coordinated their investigation with law enforcement. WCDSS spoke with collateral sources, completed a history check and interviewed family members. There were adult surviving siblings; however, the record does not reflect they were contacted or interviewed.

WCDSS interviewed the SM at the hospital on 5/25/2023 at approximately 11:00PM and learned that on that date, the SM left the SC in the care of his father and went to work at approximately 6:50PM. A short time later, the SF's paramour, who was also working at the same establishment as the SM, advised her something happened at their home regarding the SC and the SM needed to contact the SF right away. The SM immediately left her work and went straight to the home where she arrived at approximately 8:00PM. When the SM arrived EMS was attempting to revive the SC. WCDSS interviewed the SF at a local restaurant on 5/30/2023 at the SF's request. It was learned on 5/25/2023, the SF and the SC went to the park for a little while prior to the SF leaving the home at approximately 7:00PM for his barber appointment. The SC was in good spirits and did not display any atypical behavior. The SF asked the SC if he wanted to go to the barber with him and the SC declined expressing that he wanted to play a fishing game. The SF left the SC in the care of the PGF while he left the home. Both the SM and the SF expressed no concerns with the PGF's care of the SC, he had been left to care for

the SC many times in the past. Both the SM and SF described the SC's demeanor in the days leading up to the SC's demise as being cheerful and loveable, with no concerning behaviors. The SF was adamant that the child was bullied at school and as a result the SC took his own life. WCDSS interviewed the PGF and learned that while the PGF was caring for the SC during the time SF was at the barber, he had not heard the SC making any noise in the home for a short time, so he went to look for the child. The PGF searched the home and lastly went to the backyard and found the child had hung himself on the fence in the backyard. The SC used a measuring tape around his neck to hang himself. The PGF could not lift the SC to get him off of the fence, so he called the SF for assistance. The SF arrived back at the home and took the child off the fence and called 911. EMS arrived at the scene and attempted life saving measures, but they were unsuccessful. The SC was transported to the hospital where he was pronounced deceased.

WCDSS learned through collateral contacts that the SC was in therapy, and he had a scheduled appointment for therapy the day of his death; however, the SF who was to take him failed to do so stating his employer would not approve the time off from work. Mental health professionals reported the parent's divorce and behaviors had a significant negative impact on the SC and that is what contributed to the SC having behaviors at home and at school. The record reflected that mental health professionals confirmed the child did not have any suicidal ideations or plans that were disclosed during any of the appointments with the SC. The SC was suspended from school on or about 5/18/2023 for pulling a peer's hair after that child teased him. The parents attempted to speak with the school regarding some of the issues the child was having at school a couple of months prior to his death, but the record reflected the parents were dismissed by the school on at least one occasion. Additional collaterals that may have been able to provide more insight on the family were not contacted, for example the adult half-siblings that moved out of the home due to the parent's unstable relationship and the SF's behavior towards them. Bereavement and mental health services were offered to the family. The allegations were determined, and the CPS investigation was closed.

Official Manner and Cause of Death

Official Manner: Suicide
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

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
064879 - Deceased Child, Male, 10 Yrs	064881 - Father, Male, 40 Year(s)	DOA / Fatality	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064881 - Father, Male, 40 Year(s)	Educational Neglect	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064881 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064881 - Father, Male, 40 Year(s)	Lack of Medical Care	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064881 - Father, Male, 40 Year(s)	Lack of Supervision	Unsubstantiated

064879 - Deceased Child, Male, 10 Yrs	064880 - Mother, Female, 38 Year(s)	DOA / Fatality	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064880 - Mother, Female, 38 Year(s)	Educational Neglect	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064880 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064880 - Mother, Female, 38 Year(s)	Lack of Medical Care	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064880 - Mother, Female, 38 Year(s)	Lack of Supervision	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064882 - Grandparent, Male, 69 Year(s)	Lack of Medical Care	Substantiated
064879 - Deceased Child, Male, 10 Yrs	064882 - Grandparent, Male, 69 Year(s)	Lack of Supervision	Substantiated
064879 - Deceased Child, Male, 10 Yrs	064882 - Grandparent, Male, 69 Year(s)	DOA / Fatality	Unsubstantiated
064879 - Deceased Child, Male, 10 Yrs	064882 - Grandparent, Male, 69 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?	☒	☐	☐	☐
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's paramour, who had consistent contact with the SC and who resided in the home was not interviewed. The record reflected there being opportunities for the paramour to be interviewed face to face.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to

				Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☒	☐	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
WCDSS offered the family bereavement and mental health services following the death of the SC. Both parents were reluctant to engage but eventually accepted and enrolled.

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)	Allegation Outcome	Compliance Issue(s)
02/18/2023	Deceased Child, Male, 10 Years	Mother, Female, 38 Years	Inadequate Guardianship	Substantiated	Yes
	Deceased Child, Male, 10 Years	Father, Male, 40 Years	Inadequate Guardianship	Substantiated	

Report Summary:
An SCR report dated 2/18/2023 alleged the mother became physically aggressive with the then 10yo SC. The SM hit the SC several times with a shoe until he was screaming and crying in pain and eventually running from SM. SF video recorded the event and did not act to protect the SC other than verbally telling SM to stop hitting child. The SM was verbally abusive to the child during this incident including saying inappropriate things to child.

Report Determination: Indicated **Date of Determination:** 04/19/2023

Basis for Determination:
WCDSS interviewed the parents and SC. The SM admitted to hitting child. WCDSS viewed the video which showed the event took place. The BF admitted to witnessing the event and video recording it without intervening to protect the child. The SM was heard in the video saying inappropriate things to the SC. Mental health professionals reported that the child experienced anxiety and trauma from issues occurring in the home. The case was closed and opened to a FSS to continue to support the family.

OCFS Review Results:
WCDSS made home visits and interviewed the parents and child. The SC disclosed feeling safe with both parents. The investigation was appropriately determined and opened to preventive services. There was an active order of protection in place against both parents to refrain from fighting in the presence of the SC. WCDSS did not add the SF's paramour to the case despite her living in the home and having an active role in the case. The paramour was not interviewed nor sent a notification of existence or of indication. The record reflected the paternal grandparents also lived in the home, but they were not added to the case because they were out of the country at the time the case was called in.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
WCDSS did not add adults to the case who resided in the home at the time of the report. The SF’s paramour had an active role in the case, and she was not interviewed, therefore important information related to safety and risk was not gathered.

Legal Reference:
18 NYCRR 432.1 (o)

Action:

WCDSS will make casework contacts per 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.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/21/2021	Deceased Child, Male, 8 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Male, 8 Years	Mother, Female, 37 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 8 Years	Father, Male, 38 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Male, 8 Years	Father, Male, 38 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Male, 8 Years	Father, Male, 38 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Report Summary:
An SCR report dated 7/21/2021 alleged the mother and the father were failing to provide adequate supervision to the then 8yo SC on an ongoing basis. The parents left the child alone while they were at work. Both parents were aware and failed to plan for the child.

Report Determination: Indicated | **Date of Determination:** 08/30/2021

Basis for Determination:
WCDSS interviewed the parents and the SC separately and learned that there was an active temporary stay away order of protection (OP) issued on 8/3/2021 against the SF in favor of the SM and SC. WCDSS learned that the SF was violating the OP on a consistent basis. The parents were divorced and continued to have marital issues after the divorce that were having an impact on the SC. The paternal grandparents lived in the home and provided supervision for the SC when the parents were not home. The case was closed and indicated.

OCFS Review Results:
WCDSS observed the home to be appropriate and meeting a minimal degree. The subject child was observed and interviewed. The SM had filed for an OP against the SF to which he was violating. The SM was referred to DV services and was compliant. The SC was on the waitlist for mental health services by the end of the investigation. WCDSS offered the SM preventive services, but they were declined. The adult sibling’s interview lacked safety related information and the GFA was not interviewed.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
WCDSS briefly interviewed the adult sibling who lived in the home. The interview lacked information related to safety or risk. The paternal GFA was not interviewed at all despite him living in the home.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
WCDSS will make casework contacts per 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..

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

The record reflected one unfounded CPS investigation on 12/9/2014 with concerns of INGD and PDAM against the SF for the then 2yo SC, 11yo half sibling and 13yo half sibling. It was alleged that the SF physically attacked the SM while intoxicated in the presence of the children. The CHN were enrolled in counseling and the SM referred to domestic violence services.

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: 04/27/2023

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?	☐	☒	☐	☐
If not, how many days was it overdue? The initial FASP should have been completed within 7 days of the indicated CPS case. A FASP was never completed for this case.				
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: WCDSS opened a preventive case as a result of an indicated cps investigation that was closed on 4/19/2023. WCDSS provided the services to the family. The record did not reflect whether services provided had met the service needs as outlined and a FASP was not complete.				

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?

☒Yes ☐No

Issue:	Timeliness of completion of FASP
Summary:	The initial FASP was not completed for this case. A plan amendment was not completed following the fatality. The purpose of a plan amendment is to describe/document significant changes in the status of a case.
Legal Reference:	18 NYCRR428.3(f)
Action:	WCDSS will complete timely and accurate FASPs. WCDSS will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death.

Preventive Services History

A Family Service Stage was opened on 4/27/2023 and remained open at the time of death due to an indicated CPS investigation that was opened to services. The CPS case had concerns for the SM excessively spanking the child with a shoe and the BF video recording it without acting to protect. The child did not want to attend school or therapy. The case was open to continue to provide services and supervision as the family worked through custody and setting up a visitation schedule. There was an active refrain from order of protection against both parents as a result of court conflicts.

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