Office of Children and Family Services

# Child Fatality Report

## Report Identification Number: BU-19-043

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

## Issue Date: May 11, 2020

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☒ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

## Abbreviations

| | | |
|---|---|---|
| **Relationships** | | |
| BM-Biological Mother | SM-Subject Mother | SC-Subject Child |
| BF-Biological Father | SF-Subject Father | OC-Other Child |
| MGM-Maternal Grand Mother | MGF-Maternal Grand Father | FF-Foster Father |
| PGM-Paternal Grand Mother | PGF-Paternal Grand Father | DCP-Day Care Provider |
| MGGM-Maternal Great Grand Mother | MGGF-Maternal Great Grand Father | PGGF-Paternal Great Grand Father |
| PGGM-Paternal Great Grand Mother | MA/MU-Maternal Aunt/Maternal Uncle | PA/PU-Paternal Aunt/Paternal Uncle |
| FM-Foster Mother | SS-Surviving Sibling | PS-Parent Sub |
| CH/CHN-Child/Children | OA-Other Adult | |
| **Contacts** | | |
| LE-Law Enforcement | CW-Case Worker | CP-Case Planner |
| Dr.-Doctor | ME-Medical Examiner | EMS-Emergency Medical Services |
| DC-Day Care | FD-Fire Department | BM-Biological Mother |
| CPS-Child Protective Services | | |
| **Allegations** | | |
| FX-Fractures | II-Internal Injuries | L/B/W-Lacerations/Bruises/Welts |
| S/D/S-Swelling/Dislocation/Sprains | C/T/S-Choking/Twisting/Shaking | B/S-Burns/Scalding |
| P/Nx-Poisoning/ Noxious Substance | XCP-Excessive Corporal Punishment | PD/AM-Parent's Drug Alcohol Misuse |
| CD/A-Child's Drug/Alcohol Use | LMC-Lack of Medical Care | EdN-Educational Neglect |
| EN-Emotional Neglect | SA-Sexual Abuse | M/FTTH-Malnutrition/Failure-to-thrive |
| IF/C/S-Inadequate Food/ Clothing/ Shelter | IG-Inadequate Guardianship | LS-Lack of Supervision |
| Ab-Abandonment | OTH/COI-Other | |
| **Miscellaneous** | | |
| IND-Indicated | UNF-Unfounded | SO-Sexual Offender |
| Sub-Substantiated | Unsub-Unsubstantiated | DV-Domestic Violence |
| LDSS-Local Department of Social Service | ACS-Administration for Children's Services | NYPD-New York City Police Department |
| PPRS-Purchased Preventive Rehabilitative Services | TANF-Temporary Assistance to Needy Families | FC-Foster Care |
| MH-Mental Health | ER-Emergency Room | COS-Court Ordered Services |
| OP-Order of Protection | RAP-Risk Assessment Profile | FASP-Family Assessment Plan |
| FAR-Family Assessment Response | Hx-History | Tx-Treatment |
| CAC-Child Advocacy Center | PIP-Program Improvement Plan | yo- year(s) old |
| CPR-Cardiopulmonary Resuscitation | ASTO-Allowing Sex Abuse to Occur | |

# Child Fatality Report

## Case Information

**Report Type:** Child Deceased
**Age:** 12 year(s)
**Jurisdiction:** Allegany
**Gender:** Female
**Date of Death:** 11/26/2019
**Initial Date OCFS Notified:** 11/29/2019

### Presenting Information

A 7065 Reporting Form was submitted which stated on 11/26/19, the 12-year-old subject child committed suicide by hanging.

### Executive Summary

This fatality report concerns the death of a 12-year-old female subject child (SC) that occurred on 11/26/19. The child died during an open preventive services case that was initiated by Allegany County Department of Social Services (ACDSS) in May 2019. This services case was opened to assist the child's mother (BM) and parent substitute (PS) with navigating SC's numerous mental health needs, as well as to learn better coping mechanisms as a family. A completed 7065 Reporting Form was sent to OCFS on 11/27/19. An autopsy was completed. The cause of death was determined to be hanging, and the manner was suicide.

At the time of the child's death, she resided with her mother and parent substitute; there were no surviving siblings or other children in the household. The child's biological father was a registered sex offender and had no contact with the child since 2012. The child had been diagnosed with clinical concerns since the age of 5 and exhibited self-harming behaviors for several years leading up to her death. The child regularly visited mental health providers and prescribed medication. The child attempted suicide in April 2019, which resulted in inpatient psychiatric treatment and initiated the opening of the preventive services case. At the time of the child's death, her mother and parent substitute had been compliant with the child's mental health needs and had taken steps to limit the child's access to unsafe objects. The school was also up to date with the concerns.

On 11/25/19, the child, her mother and parent substitute went to bed at approximately 9:30 PM. The mother awoke at 6:00 AM on 11/26/19 and went to see if the child was awake. The mother found the child was not in her bedroom, or inside the home. The mother and parent substitute looked for the child outside and found her hanging from a tree with a rope around her neck. It was determined the child exited her bedroom through a window. The mother and parent substitute contacted emergency services, cut the child down and began performing cardiopulmonary resuscitation. First responders arrived shortly thereafter and took over; however, the child had been deceased for several hours. The child's time of death was found to be around 12:00 midnight on 11/26/19.

When ACDSS learned of the child's death, they promptly reached out to the family to offer services. The child's mother, parent substitute, and service providers felt the child's mental health had been deteriorating over the days leading up to her death, and in response, the mother had scheduled for the child to be seen for an emergency appointment with her mental health practitioner on the afternoon of 11/26/19. There was no criminality found on behalf of the mother or parent substitute, nor was there any cause to suspect either's actions or inaction led to the child's suicide. ACDSS gathered sufficient information surrounding the incident, and after several attempts to engage the mother and parent substitute in grief and bereavement counseling, the preventive services case was closed in January 2020.

## 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?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

**Explain:**
This was not an SCR reported fatality.

**Was the decision to close the case appropriate?** Yes

**Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements?** Yes

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

**Explain:**
The record reflected supervisory consultations throughout the case. The level of casework activity was commensurate with the 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:** 11/26/2019 **Time of Death:** 12:00 AM (Approximate)

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

**County where fatality incident occurred:** Allegany
**Was 911 or local emergency number called?** Yes
**Time of Call:** 06:32 AM
**Did EMS respond to the scene?** Yes
**At time of incident leading to death, had child used alcohol or drugs?** Unknown
**Child's activity at time of incident:**

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

**Did child have supervision at time of incident leading to death?** Yes
**How long before incident was the child last seen by caretaker?** 9 Hours
**At time of incident supervisor was:**

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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 | No Role | Female | 12 Year(s) |
| Deceased Child's Household | Mother | No Role | Female | 32 Year(s) |
| Deceased Child's Household | Mother's Partner | No Role | Male | 57 Year(s) |

**LDSS Response**

On 11/27/19, ACDSS submitted a completed 7065 Reporting form to OCFS regarding the death of SC, which occurred on 11/26/19. At the time of the fatality, the family was involved in an ongoing preventive services case which was opened in May 2019 to address SC's ongoing mental health needs. SC had a previous suicide attempt in April 2019, which had prompted a CPS investigation as well as the prevention services.

On 11/25/19, the prevention service provider had spoken at length with BM. BM explained to the provider that SC had snuck out of her bedroom during the night of 11/22/19, took some of PS' alcohol and went into the garage to drink. BM said SC had also found a knife, which she used to cut her thighs. BM stated she confronted SC about the behaviors and then had SC bring out any objects in her bedroom she could use to self-harm. BM stated SC had tools in her room that belonged to PS, a rope, and several smaller objects. BM confiscated all the items and asked SC what she was planning to do with them. BM reported SC said she was going to use the tools to break into a school vending machine, and she was going to use the rope to "make a noose." BM denied SC had an actual plan to kill herself. BM reported SC had just been to her doctor earlier in the day and all seemed okay; however, SC had been sneaking into the garage during the past several nights to drink and watch television. The provider problem-solved with BM and both agreed SC's behaviors appeared to be escalating. A plan was made to have SC seen for an emergency appointment with her mental health counselor, and a discussion of possible placements for SC was considered. BM explained she was able to get SC in with her counselor for the following afternoon. BM also contacted PINS and scheduled an intake appointment for 12/2/19.

On this same date, the prevention provider met with SC for approximately one hour at her school. During this meeting, SC denied feeling suicidal and denied feeling as though she needed to go into the hospital. SC expressed feeling upset regarding restrictions placed on her by BM, and how BM expects her to be "perfect" all the time. The provider noted SC appeared to be in good spirits by the end of their conversation, and SC had talked about looking forward to dying her hair in the coming days. The provider spoke with SC's school guidance counselor on this date as well, and the guidance counselor stated she spoke with BM earlier that morning. It was agreed her behaviors seemed to be escalating. The provider attempted to reach SC's mental health counselor via phone but was unsuccessful.

On 11/26/19, after hearing SC had taken her own life, ACDSS and the prevention case manager reached out to BM and PS promptly to offer services and any assistance that the family may need. ACDSS obtained police reports and a copy of the autopsy and death certificate. Throughout the services case, ACDSS had been in regular contact with the family, the preventive workers, and those involved with treating SC's mental health concerns. At the time of SC's death, SC had been compliant with attending mental health appointments and taking her medication. BM was also compliant with all providers and was reaching out regularly and for additional assistance when needed. ACDSS spoke with several collateral sources and found no reason to suspect abuse or maltreatment led to SC's suicide. The services case was closed on 1/27/20.

## 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 reviewed by an OCFS approved Child Fatality Review Team?** Yes
**Comments:** This fatality was reviewed by the Allegany County Child Fatality Review Team.

## CPS Fatality Casework/Investigative Activities

| | Yes | No | N/A | Unable to Determine |
|---|---|---|---|---|
| **All children observed?** | ☐ | ☐ | ☒ | ☐ |
| **When appropriate, children were interviewed?** | ☐ | ☐ | ☒ | ☐ |
| **Contact with source?** | ☐ | ☐ | ☒ | ☐ |
| **All appropriate Collaterals contacted?** | ☒ | ☐ | ☐ | ☐ |
| **Was a death-scene investigation performed?** | ☒ | ☐ | ☐ | ☐ |
| **Coordination of investigation with law enforcement?** | ☒ | ☐ | ☐ | ☐ |
| **Was there timely entry of progress notes and other required documentation?** | ☒ | ☐ | ☐ | ☐ |

**Additional information:**
This was not an SCR reported fatality; however, ACDSS spoke with family members and numerous collateral sources to obtain information surrounding SC's death.

## 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** | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |

**Additional information, if necessary:**
ACDSS offered the family appropriate services in response to SC's death.

**Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?** N/A
**Explain:**
There were no surviving siblings or other children in the household.

**Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality?** Yes
**Explain:**
ACDSS provided grief and bereavement referrals to SC's family in response to the fatality.

## History Prior to the Fatality

## Child Information

| | |
|---|---|
| **Did the child have a history of alleged child abuse/maltreatment?** | Yes |
| **Was the child ever placed outside of the home prior to the death?** | No |
| **Were there any siblings ever placed outside of the home prior to this child's death?** | N/A |
| **Was the child acutely ill during the two weeks before death?** | No |

## CPS - Investigative History Three Years Prior to the Fatality

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Allegation Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 04/16/2019 | Deceased Child, Female, 11 Years | Mother, Female, 31 Years | Educational Neglect | Substantiated | Yes |
| | Deceased Child, Female, 11 Years | Mother, Female, 31 Years | Inadequate Guardianship | Substantiated | |
| | Deceased Child, Female, 11 Years | Mother's Partner, Female, 56 Years | Educational Neglect | Substantiated | |
| | Deceased Child, Female, 11 Years | Mother's Partner, Female, 56 Years | Inadequate Guardianship | Substantiated | |

**Report Summary:**
This report was received with concerns SC had a history of self-harming behaviors, and while SM and PS were aware, they regularly called SC names, dragged SC by her hair, and forced her to stand in corners for extended periods of time. The report further alleged the adults left knives accessible to SC, and on 4/15/19, SC cut herself with a knife and attempted to hang herself from a tree by shoelaces. SC had ligature marks on her neck as well as lacerations on her neck, arms, and legs as a result.

**Report Determination:** Indicated | **Date of Determination:** 07/22/2019

**Basis for Determination:**
ACDSS met with the family numerous times and learned of a very strained relationship between BM, PS and SC. ACDSS worked diligently with service providers to implement services and safety plans regarding SC in home and school. At the close of the investigation, SC was compliant with all services and treatment recommendations, and the relationship between SC and BM improved. ACDSS found evidence to support the allegations and noted SM and PS' treatment of SC and their inability to manage SC's mental health were the driving factors behind SC's self-harming behavior. A services case was opened and ongoing at the time the CPS investigation was closed.

**OCFS Review Results:**
There were numerous progress notes entered more than 30 days past their event dates.

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

**Issue:**
Timely/Adequate Case Recording/Progress Notes

**Summary:**
There were numerous progress notes entered more than 30 days past their event dates.

**Legal Reference:**
18 NYCRR 428.5

**Action:**

ACDSS will enter progress notes contemporaneously as events occur.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 12/08/2017 | Deceased Child, Female, 10 Years | Mother, Female, 30 Years | Inadequate Guardianship | Far-Closed | Yes |
| | Deceased Child, Female, 10 Years | Mother, Female, 30 Years | Lack of Medical Care | Far-Closed | |

**Report Summary:**
This report was received with concerns SC had clinical diagnoses and a history of suicidal ideation; however, BM failed to follow through with an evaluation for SC. The report further alleged SC had issues with sleeping that were not addressed, and when SC was 4 years old, BM pretended to kidnap her to teach her a lesson which caused lasting trauma to SC.

**OCFS Review Results:**
ACDSS appropriately tracked this investigation as FAR. ACDSS explored the concerns with BM and SC and followed up with services providers involved with the family. SC's mental health counselor had no concerns SC was suicidal and did not recommend a higher level of care. SC was linked with counseling, PINS, after school activities and Big Brothers/Big Sisters. There were no safety concerns at the close of the case. The case record does not reflect if SC's biological father was ever notified of this report. Numerous progress notes were entered more than one month past event dates.

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

**Issue:**
Failure to provide notice of report
**Summary:**
The case record does not reflect if SC's biological father was ever notified of this report.
**Legal Reference:**
18 NYCRR 432.2(b)(3)(ii)(f)
**Action:**
ACDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

**Issue:**
Timely/Adequate Case Recording/Progress Notes
**Summary:**
There were numerous progress notes entered more than 30 days past their event dates.
**Legal Reference:**
18 NYCRR 428.5
**Action:**
ACDSS will enter progress notes contemporaneously as events occur.

| Date of SCR Report | Alleged Victim(s) | Alleged Perpetrator(s) | Allegation(s) | Status/Outcome | Compliance Issue(s) |
|---|---|---|---|---|---|
| 12/20/2016 | Deceased Child, Female, 9 Years | Mother, Female, 29 Years | Inadequate Guardianship | Far-Closed | Yes |

**Report Summary:**
This report was received with concerns BM was locking SC in her bedroom at night to prevent SC from getting into the refrigerator and sneaking out of the house while she and PS were asleep. There were further concerns SC was urinating and defecating on herself due to not being able to leave her room when needed.

**OCFS Review Results:**
ACDSS appropriately tracked this investigation as FAR. ACDSS explored the concerns with BM and found SC was engaged with multiple service providers who approved the method of BM locking SC in her room at night. ACDSS suggested door alarms, and assisted BM with installing them. ACDSS acknowledged SC had mental health and behavioral concerns, and spoke with providers involved with the family, who informed ACDSS BM was compliant with SC's needs. There were no safety concerns at the close of the case. The case record does not reflect if SC's biological father was ever notified of this report.

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

**Issue:**
Failure to provide notice of report

**Summary:**
The case record does not reflect if SC's biological father was ever notified of this report.

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

**Action:**
ACDSS will notify the subjects and other adults named in a report, as well as absent biological parents, in writing, no later than seven days after receipt of the oral report.

[redacted]

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

From 2012 to 2015, the family was involved in one unfounded CPS investigation and one FAR case, with common allegations of IG and LS. Additionally in 2015, BM was indicated for XCP, IG, and L/B/W regarding SC, which led to a mandated preventive case; however, the indication of the allegations was overturned.

### Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

## 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:** 05/18/2019

### 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:**<br>The Families Together program provided preventive services to the family throughout the open case. | | | | |

**Preventive Services History**

On 5/6/19, a voluntary preventive services case was opened in response to an indicated CPS report received on 4/16/19. The services case was opened to address and assist SM and PS with navigating SC's numerous mental health needs, as well as to learn better coping mechanisms as a family. The case was open at the time of SC's suicide, and closed on

1/16/20 because of her death.

On 6/2/15, a mandated preventive services case was opened as a result of an indicated CPS investigation with concerns BM and PS were not appropriately managing SC's behaviors and mental health concerns. The preventive case focused on parenting skills, coping mechanisms, and appropriate discipline. The family was linked with waiver services and the Big Brothers/Big Sisters program, as well as medication management, mental health counseling and a parenting program. BM and PS complied with the requirements and the services case was closed on 4/12/16.

On 8/19/14, a voluntary preventive services case was opened after a referral from PINS due to SC's ongoing behavioral concerns. The family was linked with mental health and prevention services in the community before closing the case on 1/28/15.

## 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