pennsylvania
DEPARTMENT OF PUBLIC WELFARE

# REPORT ON THE FATALITY:

**Kayden Williams**

**Date of Birth: 12/24/2012**
**Date of Death: 05/26/2013**
**Date of Oral Report: 05/28/13**

## FAMILY NOT KNOWN TO:

**Allegheny County Office of Children Youth and Families**

## REPORT FINALIZED ON:

**1/20/14**

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

**Reason for Review:**

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Allegheny County has convened a review team in accordance with Act 33 of 2008 related to this report. .

**Family Constellation:**

| Name: | Relationship: | Date of Birth: |
|---|---|---|
| Kayden Williams | Victim Child | 12/24/2012 |
| [redacted] | Mother | [redacted]1992 |
| | Father | [redacted]1992 |

**Notification of Child (Near) Fatality:**

Allegheny County Office of Children Youth and Families (ACOCYF) received a [redacted] report from [redacted] on 5/28/13 stating that Kayden was brought to the emergency room on 5/26/13 in [redacted] and that he died after arriving at the hospital. The father reported that he had awakened to find Kayden not breathing. There were no underlying medical conditions or explanations provided regarding the death. The post mortem skeletal survey revealed [redacted] and a [redacted] age undetermined. The [redacted] were considered to be at least a few weeks old and the injuries were considered suspicious [redacted]. There was no explanation for the event that caused the child's death, and more information was expected to be provided by the medical examiner's report. The report was registered for [redacted] and processed as a fatality report.

**Summary of DPW Child (Near) Fatality Review Activities:**

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] family. The regional office also participated in the County Internal Fatality Review Team meeting on June 21, 2013 and July 18, 2013 where the medical examiner's reports and autopsy findings were presented.

**Children and Youth Involvement prior to Incident:**

There was no previous CYS involvement regarding Kayden Williams prior to his death; however, the mother was involved with Mercer and Lawrence County Children and Youth Services as a child. The father's family was also involved with ACOCYF when he was a child, with the primary focus being on his sibling. The father also has a history with the Allegheny County Juvenile Probation Office.

Kayden's mother has a history of involvement as a child with Lawrence County CYS dating back to the early 2000's. The child's maternal grandmother (MGM), had addiction issues and a history of homelessness. Because of this, the mother resided with a caregiver who later became her legal guardian. While with the caregiver, she disclosed [redacted] by one of MGM's former boyfriends, who was later prosecuted for the [redacted]

In 2002, there were concerns of [redacted] by the caregiver which resulted in the mother being placed in foster care for a period of time. She was later returned to the caregiver and the case was closed.

In 2003, the case was reopened by Lawrence County CYS due to [redacted]. At that time, the caretaker's family moved to Mercer County and the case was referred to Mercer County CYS. The mother had [redacted] while active with Lawrence County CYS. In 2000, she had been [redacted] while the [redacted] were being investigated, and had [redacted] from October 2002 to May 2003.

Mercer County CYS became involved with the child and her legal guardians in the beginning of 2003. [redacted] Her case was closed when she turned 18 as she did not wish to remain in care.

The father was involved with ACOCYF on and off throughout his childhood. [redacted] The father spent a brief period of time in foster care in 1992. He and his brother, [redacted] were reunified with their biological father, Kayden's paternal grandfather. The case was most recently active between 10/07/09 and 2/23/10 due to a parent-child conflict between the paternal grandfather and [redacted] in which the agency [redacted].

The father also was involved with the Allegheny County Juvenile Probation Office (JPO), when he was 15 years old due to shoplifting. He was ordered to six months probation and community services at [redacted]. His JPO case was closed once he completed the community service.

**Circumstances of Child (Near) Fatality and Related Case Activity:**

There was no formal custody agreement regarding Kayden, but he resided with his mother during the week and with his father on weekends. On the weekend in question, he had been in

his father's care since 5/24/13. The father stated that he put Kayden to bed after his bottle around 11:00 pm the evening of 5/25/13. Kayden was placed on a full mattress, placed on his back with his head leaning to one side. The father reported that he slept in the same bed as Kayden, but on the other end of the bed. He reported waking up between 5:00 am and 6:00 am and made Kayden a bottle. When he went to give him the bottle, he found Kayden in the same position, unresponsive, warm to the touch, but blue in color. The father reported that he started CPR, although he admitted that he did not know how to do it properly.

He could not locate his cell phone, so he ran to the fire station. At 6:54 am, fire personnel contacted 911, and provided Kayden with oxygen while beginning CPR. The ambulance arrived at [redacted] at 7:32 am, and Kayden was pronounced dead at 8:10 am. There was no explanation provided regarding the lapse in time from when the father stated he awoke and when he ran to the fire station. The mother reported that she had no concerns regarding the father's care of Kayden.

The post mortem skeletal survey performed on 5/26/13 revealed evidence of [redacted] Records reflect that Kayden had X-rays on 4/14/13 which [redacted] The autopsy report did not reveal [redacted] however, there was a [redacted] which was determined to have occurred at least 2-3 hours before the child's death. There were also [redacted] which were in the process of healing. The coroner believed the injuries could have occurred at the same time and were probably within 1-2 weeks prior to the child's death. Other findings noted in the autopsy were: [redacted] The coroner stated that the cause of death cannot be determined, but it is possibly the result of asphyxiation as the result of co-sleeping. There was no acute process to explain the death, but [redacted] were sent for examination.

The criminal investigation was closed on 06/04/13 as the death was not ruled a homicide, and the injuries the child sustained did not appear to cause his death. The [redacted] was [redacted] on 7/24/13 for the [redacted] in which the physician stated would have caused the child severe pain; however, it was determined that the child had injuries due to [redacted] that were determined to be unrelated to the fatality. The father [redacted] based on the medical determination of when [redacted] occurred as he was the sole caretaker for the child during that period of time. The case was referred to law enforcement regarding the [redacted] and the father was arrested on 09/23/13 and charged with aggravated assault and reckless endangerment of another person. Charges remain pending at this time, and the father remains in the [redacted] Jail awaiting trial.

**Current Case Status:**

Since there are no other children in the family, ACOCYF closed the case on 7/24/13. [redacted] resources were provided to the family.

**County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

- Strengths: ACOCYF responded immediately to the report and conducted a thorough and timely investigation.

- Deficiencies: None were noted

- Recommendations for Change at the Local Level: The team recommended adherence to the joint investigative protocol between law enforcement and the local child welfare agency in suspected cases of child abuse. The team also recommended that law enforcement consider maintaining open investigations until receipt of final findings from the medical examiner's office to support their course of action in cases in which police are investigating a child death.

- Recommendations for Change at the State Level: There were no recommendations made.

**Department Review of County Internal Report:**

The Department received a draft of the counties internal report on 11/25/13. The Department agrees with the findings and the recommendations provided in the report.

**Department of Public Welfare Findings:**

- County Strengths: ACOCYFS has developed a review team that is inclusive of the needed entities in order to complete a thorough review of the Act 33 cases. The agency also provides a detailed summary of the CPS investigation and intake assessments completed when Act 33 reports are received.

- County Weaknesses: No weaknesses were noted.

- Statutory and Regulatory Areas of Non-Compliance: There are no statutory or regulatory areas of non-compliance noted.

**Department of Public Welfare Recommendations:**

Based on the review completed by the Department, there are no recommendations at this time.