pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Ky'Heir Arthur

BORN: June 19, 2009
DATE OF DEATH: January 4, 2013
DATE OF ORAL REPORT: January 4, 2013

FAMILY WAS KNOWN TO:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:
June 10, 2015

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

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

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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, DHS 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:
Ky'Heir Arthur	Victim Child	June 19, 2009
[redacted]	Twin Sibling	2009
[redacted]	Mother	1980
[redacted]	Victim Child's Father	1981
* [redacted]	Half-Sibling	2005
* [redacted]	Half-Sibling	2000
[redacted]	Half-Sibling	1997
* [redacted]	[redacted] Father	1964
* [redacted]	[redacted] Father	1970
* [redacted]	[redacted] Father	1980

*indicates that they did not reside in the same residence as the victim child.

Notification of Child (Near) Fatality:

On January 4, 2013, Allegheny County Office of Children, Youth and Families (OCYF) received a [redacted] report [redacted] reporting that two children, the victim child and his twin sibling, died in a house fire today. The children's mother had left the three year old twin boys home alone. The referral source reported that the mother frequently leaves the children home alone.

[redacted] report also contained allegations that the mother posted on Facebook two weeks prior the children's deaths that she was trying to get rid of the children because she could no longer care for them. The mother allegedly stated that she would sell the children or "they'd be dead or gone".

Summary of DPW Child (Near) Fatality Review Activities:

The Western Regional Office of Children, Youth and Families reviewed the case file regarding this family's case. In addition, the Regional Office participated in the Allegheny County Act 33 Meeting on February 1, 2013. The ongoing and assessment caseworkers and supervisors were interviewed. In addition, the case file was reviewed which included the family's prior and current involvement with the agency. This included case dictation, family service plans, and risk and safety assessments.

Children and Youth Involvement prior to Incident:

The family had involvement with Allegheny County Office of Children, Youth and Families beginning in August of 2005 due to concerns for inadequate housing (deplorable conditions, no food or utilities), parenting issues, truancy and unsubstantiated allegations of physical maltreatment by the mother and unsubstantiated allegations of sexual assault between siblings. The agency was providing ongoing services to the family at the time of the victim child's death.

August 19, 2005 to September 21, 2006: It was alleged that the mother was using crack and [redacted] The mother had left the youngest daughter who was 6 weeks old with the mother's 91 year old grandmother while she took her two oldest daughters, who were 5 and 7 years old at the time, to the local bar in September 2005. The two oldest children were placed into agency custody on September 30, 2005 and remained placed with a family friend until January 21, 2006. The six month old child remained with relatives while the older children were placed. The mother was charged with endangering the welfare of children due to this incident. She tested positive for marijuana on two separate occasions during the first two months of involvement with the agency. [redacted] She also complied with parenting instruction and [redacted] services. This case was closed on September 21, 2006.

On August 14, 2007, a General Protective Services (GPS) report was received by Allegheny County OCYF claiming that the mother had left the two oldest children home alone. The 7 year old daughter had claimed that the 10 year old daughter had placed tape over her mouth and eyes and put her in the basement while the mother was away from the home. When the mother returned to the residence she opened the basement door letting the 7 year old child out of the

basement. The case was closed on October 16, 2007 based on the allegations not being validated.

On December 18, 2008 , Allegheny County OCYF received a Child Protective Service (CPS) report that the three year old daughter had disclosed to her paternal grandmother that the 11 year old sister had licked her between her legs. A forensic report was completed on the youngest child and no disclosure was made. This report was unfounded and closed at intake. The case was closed on February 4, 2009.

A General Protective Service (GPS) report was received by Allegheny County OCYF on October 9, 2009. The allegations were that the nine year old daughter was absent from school for six days. The police conducted a courtesy check and determined that there was a robbery at the residence. The report was screened out by the agency. The case was closed on October 13, 2009.

On March 19, 2010, Allegheny County OCYF received a GPS report [redacted]. Allegations were that the five year old daughter was acting out sexually and that she was being sexually maltreated by the 13 year old daughter. The mother purportedly beat the oldest daughter and told her not to touch the younger child anymore. No injuries were observed to this child. The 5 year old child's father filed for emergency custody of his daughter and was granted primary custody and the mother was granted supervised visitation at the paternal grandmother's home every other Saturday. The child made no disclosure and the allegations were unfounded. Case closed on March 23, 2010.

Allegheny County OCYF received another GPS report on March 26, 2010. The mother begun to act "delusional" and threaten to harm her oldest child and herself, [redacted] The four children stayed at the neighbor's home. The case was accepted for ongoing services on May 24, 2010. [redacted] A safety plan was established that if the mother returned [redacted] that the maternal grandmother would take over caregiving responsibilities for the four children that remained in the mother's care. The case was closed on July 1, 2011

On October 3, 2011, Allegheny County OCYF received a GPS report due to self-injurious behavior by the mother. The mother broke a window with her hand. There were concerns for deplorable home conditions and the children running around the home naked. [redacted] The mother was referred to community resources to address housing issues. The case was closed on November 28, 2011.

The agency received a GPS report on April 6, 2012 that claimed that the mother had left the children alone from March 30, 2012 to April 5, 2012. The reporter claimed that the mother acts as though she wants the child taken from her. Allegheny County OCYF completed a home visit on April 6, 2012 and the maternal grandmother was at the mother's residence who was caring for the children. This report was screened out and not accepted for an investigation.

Another GPS report was received on July 18, 2012 which also was screened out. The allegations stated that the family's home had no electricity and that the 12 year old daughter had poison ivy resulting in her face and eyes being swollen. A home visit was conducted and the mother was able to produce a [redacted] The electricity had been restored.

A Child Protective Services referral was received by Allegheny County OCYF on September 18, 2012 that alleged that the mother had hit her 12 year old daughter with an extension cord while she was in the shower. The mother also supposedly punched the child and bit her buttocks as well. The daughter reported that she was fearful of her mother and walked to her father's residence. The daughter was examined at Children's Hospital of Pittsburgh, and the physicians found healing marks on each of her thighs and bite mark to her buttocks. However, [redacted] physician and the physician [redacted] had different views of the level of severity and pain the child would have endured. It was determined the level of severity did not meet the definition of physical abuse and the report was unfounded. The child went to live with her biological father.

The case was accepted for ongoing family services on September 20, 2012, and [redacted] services begun on September 20, 2012 and addressed housing, home management and parenting until they closed their services on October 20, 2012 due to a service reauthorization issue, the family did not have a service provider after October 20, 2012. The family at this point only received visits from the Allegheny County OCYF caseworker.

The mother, the 15 year old daughter and the twin boys moved into a new home in [redacted] on November 27, 2012. The 15 year old child's father had passed away on July 27, 2006 due to a gunshot wound. The twin's father was incarcerated at State Correction Institute [redacted] due to a firearm violation. The case was still opened when the victim child died on January 4, 2013.

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

Approximately between 2:40 pm and 3:00 pm on January 4, 2013, the mother decided to leave the family residence and go look for her 15 year old daughter who did not return home from school at 2:40 pm as expected. The mother left the child and his three year old twin sibling alone in the home. She used her

front door key to lock both children in the home while she searched for her daughter.

The previous evening a male guest of the mother's spent the night. She admitted to possessing two bags of marijuana and noticed during the day of the incident that one of the bags was missing. Being unable to ascertain if her daughter may have taken the one bag of marijuana she chose to look for her when she did not return home from school.

While the mother was gone, the child and his twin brother decided to move a little plastic chair in front of the stove and proceeded to make a package of cookies. The stove had been "red flagged" by the gas company which indicates that the appliance is faulty and cannot be utilized. In the course of the fire, the hood of the stove collapsed preserving the contents of the stove top. According to [redacted] Fire Marshal, a grease fire would completely engulf a kitchen within 30 minutes of grease boiling leading to a fire. The plastic chair had melted in front of the stove indicating that the boys had attempted to bake the cookies.

At 3:29 pm, the [redacted] Police Department had received a fire call over their police radio and immediately responded to the scene. Then a contractor working in the neighborhood saw the fire and called it into 911 at 3:33 pm.

The child's 15 year old sister explained that after school she decided to go to her friend's house instead of coming directly home. She reported that she spent approximately one hour at her friend's house prior to leaving. Around 3:33 pm as she got into close proximity to her residence, she saw her house engulfed in flames. Within minutes of her arrival, the [redacted] Fire Department arrived on scene, and began measures to combat the fire, but the house was already completely consumed in flames.

The Police and Fire Departments initially thought that the home was abandoned until the child's sister mentioned that she lived in the residence, and that she could not find her brothers or mother. The mother arrived shortly thereafter and started questioning her 15 year old daughter where the twins were located. The mother notified the Fire Department that the twins could possibly be in the residence.

At 4:19 pm, the [redacted] Fire Marshal requested that the Homicide Detectives from the [redacted] Police Department assist [redacted]. He reported that the bodies of both children were found on the second floor of the home in separate bedrooms. One was located in the front bedroom and the other child was located in the back bedroom above the kitchen. Both children were pronounced dead at the scene at 4:33 pm.

An autopsy was performed on January 5, 2013 by Dr. [redacted] from the Allegheny County Medical Examiner's Office. He reported that the child's body had "thermal type Injuries" which is consistent with being involved in a fire. Dr. [redacted], a forensic Odontologist, had to utilize the child's dental records to identify him. It was determined that the child had died as a result of "thermal and inhalational injuries".

The child's sister was placed informally by the mother with the child's twelve-year old sister and her father. However, due to run away behaviors the child was placed [redacted] while other placement options could be explored.

The mother reported that two weeks prior to her children's deaths, she left the twins alone and when she returned the house was filled with smoke due to them attempting to cook ribs. On January 22, 2013, the mother met with Detective [redacted] and a warrant for her arrest was served. The mother was charged with two counts each of Involuntary Manslaughter, Endangering the Welfare of Children and Recklessly Endangering another Person.

Allegheny County OCYF completed [redacted] on February 1, 2013, [redacted] as perpetrator [redacted].

Current Case Status:

The mother's 7 and 12 year old daughters still reside with their fathers and both are doing well and are attending school on a regular basis.

The 15 year old daughter, [redacted] as additional family members are being explored as potential resources for this child. She is receiving [redacted] services through a provider agency.

On April 7, 2014, the mother pled guilty to two counts of Involuntary Manslaughter, two counts of Endangering the Welfare of a Child and two counts of Recklessly Endangering another Person. She was sentenced by Judge [redacted] to 18 to 36 months in a state prison and 5 years of probation upon her release.

On August 14, 2014, Allegheny County OCYF completed a [redacted]

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

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.

- Strengths:
  - Allegheny County OCYF immediately responded to the report that the children had died in the fire. The caseworker conducted a thorough investigation and ensured the safety of the surviving household member sibling. The sibling was placed initially in the home of kin.
  - The agency had an open ongoing family services case with the family at the time of the child's fatality; however, there were no community service providers working with the family at that time. After the child's fatality, the mother and the surviving sibling were provided [redacted] services.
- Deficiencies:
  - Allegheny County OCYF accepted the case for ongoing family services on September 20, 2012. The Family Service Plan was completed on November 20, 2012 which is in compliance with state regulations that require a Family Service Plan be devised within 60 days of case acceptance. During the agency's quality assurance review of the family's case file, it was determined that the agency did not comply with state regulation §3130.61 by not providing the mother and the 15 year old sibling the opportunity to sign the plan. In addition, the supervisor did not sign the Family Service Plan in the required 10 day time-frame of the plan's development which is a violation of state regulation §3490.61.
- Recommendations for Change at the Local Level:
  - The Review Team recommended consideration for filing dependency of children when families have numerous reports to the county agency, with no resolution of underlying problems or family stressors that impact child safety.
  - The Review Team recommended reinforcement of staff training and supervisory oversight on the imperative to obtain information from collateral contacts as a practice standard and utilizing Department of Human Services databases to better identify other systems that may be involved with consumers for case assessment and case planning purposes.

- The Review Team discussed the need for enhanced tracking of and decision making associated with multiple referrals to the agency, including exploration of an electronic system and enhanced search tools with the electronic case management system that flags multiple referrals to assist with assessment and decision making.

- The Review Team recommended an immediate administrative review of the policy for reauthorization of provider services as well as supervisory decisions related to timing of case transfer.

- The Review Team recommended the promotion of the use of [redacted] by agency providers for [redacted] services. This service provides 24-[redacted] services.

- The Review Team recommended that Allegheny County CYF enhance their safety checklist, used to assess family home environments for safety and to check on the status of the appliances, including asking whether appliances have been disconnected by utility companies.

- The Review Team identified need for improvements in Allegheny County OCYF assessment and understanding of domestic violence and of [redacted] challenges and their impacts on children, with focus on the need for comprehensive assessment and planning with all caregivers.

- The Review Team recommended the creation of an interdisciplinary and interagency process to provide advice and guidance for clarifying and resolving differences of professional opinion regarding the determination of occurrences of abuse and neglect.

- The Review Team recommended further assessment, including medical evaluations and consideration for forensic evaluations, for children involved with child welfare services who engage in developmentally inappropriate sexualized behaviors.

- The Review Team noted the need for continued public awareness around dangers of leaving children home alone and fire safety.

- <u>Recommendations for Change at the State Level:</u>

  - The Review Team recommended ongoing monitoring of Allegheny County OCYF's actions related to regulatory and practice issues cited above.

Department Review of County Internal Report:

The Department received the finalized version of the County Internal Report on January 2, 2015 via email. The report demonstrates a true analysis by the Review Team on the events that led up to and occurred on January 4, 2013. The Review Team's suggestions provide a strong basis for forward progress in ensuring that no other children experience the same fate as these children.

The Department responded and accepted the report via email on January 2, 2015 to [redacted], the Chair for the Review Team.

Department of Human Services Findings:

- County Strengths:
  - The caseworker assigned to complete the investigation on the child's death was thorough and detailed. Arrangements were immediately made to ensure the safety of the surviving sibling who was a household member. The caseworker reached out to her sibling's father to ask for his assistance in caring for the child, which he did accept.
- County Weaknesses:
  - The family had been involved with Allegheny County OCYF off and on for eight years prior to the children's deaths. The referrals were similar in nature; however, instead of analyzing the needs of the family the same services were rendered; hence, little progress made.
  - The family was opened for ongoing family services at the time of the children's deaths; however, no services were being rendered to the family due to a service reauthorization not being approved. Given the mother's history of drug addiction and [redacted] the Family Service Plan should have been utilized to determine if other services should have been rendered to the family.
- Statutory and Regulatory Areas of Non-Compliance:
  - As indicated above state regulation §3130.61 was violated by not having the mother and the 15 year old sibling participate in the development and signing of the family service plan. If the mother would have seen the plan she would have known that the expectation of the mother was to provide and maintain living conditions that were free from health and safety hazards and to ensure supervision of children at all times.

State regulation §3490.61 was also violated when the supervisor did not sign the family service plan within 10 days of the plans development. If the supervisor would have reviewed the plan in a timely matter then the issue of no services being offered to the family may have been addressed and services could have been rendered. A service provider may not have been able to prevent the events of January 4, 2013, but their services may have been beneficial in the constant reminders to the mother not to leave her children alone.

Department of Human Services Recommendations:

Throughout the history of this case which began in 2005, there was a predominant theme that the mother would leave her young children alone in the family residence. Each time this matter was addressed when a referral was received; however, there appeared be a failure in looking back at the previous reports to see that the mother had a strong history of leaving her children alone. A mechanism needs to be devised internally to ensure that the investigative caseworkers review the entire history prior to closing out an investigation to ensure that common themes are not overlooked.

The Department fully supports the Review Team's recommendations which will move the agency forward in providing the optimal service array to the families of Allegheny County.