pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Xavier Washington

Date of Birth: 6/5/11
Date of Death: 3/2/13
Date of Oral Report: 3/5/13

FAMILY KNOWN TO:

Allegheny County Children, Youth and Family Services

REPORT FINALIZED ON:

08/10/2015

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))

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 convened an Act 33 Child Fatality Review Team on April 18, 2013.

Summary of Review

Family Constellation:

Name:	Relationship:	Date of Birth:
Household members:		
Xavier Washington	Victim Child	6/5/11
[redacted]	Twin Brother	[redacted]/11
	Half Brother	[redacted]/04
	Half Brother	[redacted]/08
	Maternal Aunt	[redacted]/77
	Maternal Cousin	[redacted]/06
	Maternal Cousin	[redacted]/94
	[redacted] Daughter	[redacted]/11
	Son	[redacted]/12
Non-household members:		
[redacted]	[redacted] intimate partner	[redacted]/89
	Mother	[redacted]/85
	Father	[redacted]/70
	[redacted] Father	[redacted]/71
	[redacted] Father	[redacted]/90

Notification of Child (Near) Fatality:

On March 2, 2013, police responded to [redacted] residence after receiving a 911call at 6:00 am regarding Xavier Washington's death. Xavier was transported directly to the Medical Examiner's office with chemical burns to his chest, back, and left side. The cause of death is still under review. The child was not taken to any of the local hospitals given he was pronounced dead at the family's residence by the Allegheny County Medical Examiner. The Medical Examiner was not aware of the protocol to contact ChildLine regarding the child's death. He is now aware of this protocol.

On March 5, 2013, the Western Region, Office of Children, Youth and Families personnel made a report to ChildLine regarding the child's fatality after discussing the report with the investigative team at Allegheny County Office of Children, Youth and Families; hence, a delay in this report being certified as a child fatality.

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 Western Region Office of Children, Youth and Families interviewed the current assigned caseworker, the detective [redacted], and the three alleged perpetrators [redacted]. The regional office also reviewed the medical records from Children's Hospital of Pittsburgh and participated in the Act 33 Fatality Review meeting on April 18, 2013.

Summary of Services to Family:

On April 11, 2012, the current case was opened when the family was referred due to concerns that the child's mother was [redacted], was abusing drugs, and the home was found to be dirty with minimal food. While the child's mother [redacted] were with the maternal grandmother and Xavier and [redacted] were with a friend of the child's mother. Allegheny County Children, Youth and family Services completed home visits to the maternal grandmother's home and the home of the friend of the child's mother to see all four of the children.

Upon the mother's [redacted], the children were placed back into the mother's care and Allegheny County Children, Youth and Family Services attempted to assist the family by providing [redacted] services [redacted]. The child's mother met with the [redacted] on an almost daily basis, from April 17, 2012 until May 9, 2012 when Allegheny County Children, Youth and Family Services had contacted the child's mother for her to perform a drug screen. [redacted] continued to see the family several times

including May 10, 18, 30, and 31, 2012. Allegheny County Children, Youth and Family Services completed a home visit during this time on May 4, 2012.

On May 31, 2012, the intake case worker had a conversation with [redacted] at which time the provider agency reported that they would be ending their services to the mother due to the mother no longer cooperating with services.

On June 1, 2012, Allegheny County Children, Youth and Family Services conducted an unannounced home visit. The children were in the care of the child's mother. Allegheny County Children, Youth and Family Services noted concerns of bottles with rotten formula in them, a marijuana cigarette in the ash tray, and beer cans lying around the home. The child's mother admitted to drinking and smoking marijuana.

At the request of Allegheny County Children, Youth and Family Services [redacted] did a follow up visit on June 2, 2012 to address the housing issues with the child's mother. [redacted] found the home to be in acceptable condition despite the child's mother reporting that she had not cleaned since Allegheny County Children, Youth and Families conducted their home visit the day prior.

On June 4, 2012, the child's mother was referred [redacted]. The child's mother failed to follow through [redacted]. The caseworker provided the child's mother with resource information for [redacted]. The child's mother never [redacted]. The caseworker also connected the child's mother to [redacted], which provides parenting groups and [redacted] sessions, but the workers were unable to reach the child's mother on a consistent basis.

[redacted] did not close out their services until June 15, 2012 (their last contact summary). The case was then transferred from intake to family services on June 19, 2012.

On July 12, 2012, the Allegheny County Children, Youth and Family, family services caseworker contacted [redacted] and the provider reported closing the family's case two weeks prior due to the child's mother missing appointments and not cooperating with services.

The caseworker attempted to reach the child's mother via telephone on July 24, 2012, but her phone was not working. The caseworker then did an unannounced home visit on July 25, 2012 and no concerns were noted. The child's mother had been referred to [redacted] and follow through with the recommendations. [redacted] provided mother with contact information regarding [redacted]

[redacted]. The child's mother was to follow through with connecting to these programs.

On August 22, 2012, [redacted] called to report that the child's mother left the children with the maternal uncle, the child's mother's utilities were shut off, uses drugs, and does not care for the children.

On August 23, 2012, Allegheny County Children, Youth and family Services made a home visit to the maternal uncle's home. The maternal uncle explained that he did not know when the mother would be back and [redacted] and Xavier may need medical care.

On August 24, 2012, [redacted] to the hospital for [redacted]. The police were called to the maternal uncle's home when the child's mother showed up and became irate when she was told that she could not go around the children. The police convinced the child's mother to let the children stay, but stated that they would allow her to take the children the next day.

On August 25, 2012, [redacted] Children's Hospital of Pittsburgh. The hospital called Allegheny County Children, Youth and Family Services to see if the child could go home with the mother. Children's Hospital contacted the call screening department as it was a Saturday. The on-call supervisor made the decision that the child could return home with the mother and then the assigned caseworker would further assess the safety of the children. The Allegheny County Children, Youth and Family Services caseworker spoke with the child's mother by phone and stressed the importance of taking the child for follow up [redacted]. The child [redacted] to his mother's care with a plan for Allegheny County Children, Youth and Family Services to re-examine the child's safety if the child's mother did not take the child for follow up [redacted].

On August 27, 2012, Allegheny County Children, Youth and Family Services made an unannounced home visit to the child's mother's home. There was no gas, but there was electricity and water. The assigned caseworker found no safety threats at that time.

An in-home safety assessment was completed on August 30, 2012 in response to the caseworker's August 27, 2012 home visit with mother and the children. The children were assessed to be safe at that time.

On September 10, 2012, Allegheny County Children, Youth and Family Services made an unannounced home visit to the child's mother's home. The gas was back on. The child's mother reported not taking the children for follow up appointments because of the location. The caseworker gave other resources for [redacted]. The child's mother reported drinking six beers twice a week when the children were asleep and stated she was not addressing [redacted]. Overall risk was determined to be moderate. Vulnerability and

access to the children were rated as high risk. [redacted], drug and alcohol use, prior abuse and neglect, condition of home, [redacted] were all found to be moderate. Due to the children being over one year old, the children were only seen on a monthly basis once [redacted] closed their services.

On October 7, 2012, the children were found home alone. The child's mother was charged with child endangerment and taken into custody due to an active warrant. The children's mother had the children go to the maternal aunt's home.

Allegheny County Children, Youth and Family Services removed the children from the maternal aunt's care on October 11, 2012 and placed them in an [redacted] foster care home due to the maternal aunt's Title 18 charges. The maternal aunt had been charged and convicted of Endangering the Welfare of a Child.

[redacted]

[redacted] Allegheny County Children, Youth and Family Services referred the maternal aunt to [redacted] for foster home certification.

It is important to note that the Allegheny County Children, Youth and Family Services caseworker was out [redacted] and the case was being covered by the caseworker's supervisor. Hence, the children were not seen by the assigned family services county caseworker or supervisor from November 9, 2012 until January 30, 2013.

On December 14, 2012, ChildLine received a GPS report for alleged medical neglect. The children were not seen medically since the Allegheny County Children, Youth and Family Services [redacted] on October 11, 2012. [redacted]. The maternal aunt failed to take him and was reportedly not answering phone calls from the medical office.

On December 19, 2012, [redacted] notified Allegheny County Children, Youth and Family Services that the maternal aunt's home was not approved due to her Title 18 conviction and failure to comply with certification requirements.

On December 21, 2012, [redacted] called Allegheny County Children, Youth and Family Services to report [redacted] and Xavier had not been seen for their wellness checks and immunizations and the medical office was unable to reach the maternal aunt. Allegheny County Children, Youth and Family Services contacted the maternal aunt by phone and she reported she was

unable to have the twins seen for the wellness checks and immunizations due to her not having their immunization records and she reported that the next appointment is not available until April 2013. The maternal aunt reportedly requested that the twin's [redacted] to be transferred from Allegheny General Hospital to Children's Hospital of Pittsburgh.

A formal request was made on December 26, 2012 to transfer the requested [redacted] was received on January 9, 2013 for all three children.

On December 26, 2012, the maternal aunt was given releases of information to have the child's mother sign to have Allegheny General Hospital records transferred to Children's Hospital of Pittsburgh.

On January 22, 2013, [redacted] called Allegheny County Children, Youth and Family services to report that the children missed three appointments since December 14, 2012 when a [redacted] was made due to concerns for medical neglect. All of the appointments were scheduled after [redacted] was made.

On January 23, 2013, a request was made for the [redacted] to provide services to the maternal aunt.

On January 30, 2013, [redacted] called Allegheny County Children, Youth and Family Services. The children were seen on January 29, 2013 for wellness checks and the physician has serious concerns for Xavier's health. Xavier was [redacted]. It is noted in Xavier's [redacted] that child had been [redacted] at least since February 24, 2012. The doctors were concerned especially due to their lack of ability to review Xavier's [redacted]. Xavier was to be referred to [redacted]

Allegheny County Children, Youth and Family Services completed home visits in the maternal aunt's home on January 30, 2013, February 8, 2013, and March 1, 2013 and no concerns were noted. [redacted] was observed walking and running. Xavier was unable to sit up on his own.

The maternal aunt claimed she did not have [redacted] for the children, which prevented her from taking the children for required medical care. The maternal aunt reported that she was having difficulties with some appointments due to lack of a [redacted] and some reportedly due to the children's [redacted] not being transferred from Allegheny General Hospital to Children's Hospital of Pittsburgh.

Xavier was seen for a [redacted] on November 21, 2012 and it was recommended that he follow up in three months and have an [redacted] was

able to be seen at the [redacted] Department at Children's Hospital of Pittsburgh on December 17, 2012. [redacted] be seen again on June 17, 2013. Xavier was seen at the [redacted] Department on December 13, 2012 and it was recommended that he have a [redacted]. He was scheduled to be seen for [redacted] on January 9, 2013 and an [redacted] follow up was scheduled for January 30, 2013. Children were seen for their well child care visit on 1/29/13. Xavier was to return in one month. The nurse indicated that the doctor has significant concerns and has not received the children's [redacted]. Xavier is also to have an appointment with the [redacted] with CHP as well as the [redacted]

On March 2, 2013, Allegheny County Children, Youth and Family Services received information that Xavier was found dead in maternal aunt's home. The child and his twin were exposed to bleach that caused respiratory difficulty and chemical burns. Xavier reportedly died from dehydration from exposure to bleach.

Children and Youth Involvement prior to Incident:

The child's mother was involved with Allegheny County Children, Youth and Family Services as a child due to concerns for her mother's alcohol use. The child's mother was in placement as a child for 8 months and the case was closed on December 31, 2002.

Between May 4, 2008 and March 17, 2009, the family was referred to the agency after the child's mother gave birth on May 2, 2008 and tested positive for THC. The mother admitted to using Marijuana for "morning sickness". The baby was not tested. The baby was full term and weighed 6 pounds 8 ounces. [redacted] The hospital did not note any concerns with the mother's bond with the newborn. The child's mother [redacted] Hospital in Pittsburgh and reported that she had baby supplies.

Between June 2009 and September 2009, [redacted] provided in home services to the family.

Between November 17, 2009 and November 19, 2009, allegations were made that the child's mother was using cocaine and alcohol on a daily basis, the home was dirty, and the mother lacked parenting skills. The case was screened out after a home visit on November, 19, 2009.

Between June 6, 2011 and November 8, 2011, the family was referred when the mother gave birth to the child and his twin brother and tested positive for THC.

The twins tested negative. The children were born premature at 29 weeks gestation. The mother did not have baby supplies. [redacted] It was noted that the mother has a [redacted] The mother received [redacted] and was referred [redacted] The intake caseworker confirmed with [redacted] on September 23, 2011 and October 25, 2011 that the mother [redacted] The case was not accepted for service.

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

On March 2, 2013, a [redacted] report was made to the Western Region Office of Children, Youth and Families after Xavier's brother, [redacted], was admitted to Children's Hospital of Pittsburgh with chemical burns. The initial report was that Xavier soiled himself and the adult caregivers removed Xavier and [redacted] from the crib and cleaned the crib with bleach, which seeped into the mattress. The adults placed the children back into the crib.

The case was referred to the Western Region Office of Children, Youth and Families due to the incident occurring in a [redacted] foster home. The Western Region Office of Children, Youth and Families completed [redacted] on April 25, 2013 and [redacted] based on the fact that all of the alleged perpetrators reported knowing the child had been in contact with bleach, but chose not to pursue medical treatment and the child died.

Current Case Status:

[redacted] was placed in foster care on March 5, 2013 following his [redacted] Children's Hospital of Pittsburgh. [redacted] appears happy and well-adjusted in his current foster home and his foster mother reports no concerns. [redacted] had follow-up medical appointments with his primary care physician, [redacted] with no further action recommended for chemical burns.

[redacted] went to [redacted] on March 3, 2013. He was previously with his twin siblings in the care of Maternal Aunt, [redacted] The agency is currently in the process of completing an interstate compact on maternal aunt, [redacted], who resides in [redacted]. He was recommended for [redacted]. He has visits [redacted] with his mother, aunts, and grandmother.

[redacted] has resided with his father in [redacted] since August 14, 2012. They recently returned to the [redacted] area.

[redacted] are currently placed together in [redacted] foster home where they have been since March 4, 2013.

Charges are pending for all of the adults who came into contact with Xavier throughout the evening of his death.

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 Children, Youth and Family Services convened an Act 33 Child Fatality Review Team on April 18, 2013.

Strengths: The Allegheny County Office of Children, Youth and Family Services immediately responded to the [redacted] report and instituted a safety plan for the surviving family members. The victim child and his twin brother both received [redacted]

Deficiencies: The agency failed to see the children face-to-face on a monthly basis.

Recommendations for Change at the Local Level: No home visits occurred from November 9, 2012 to January 30, 2013 while the assigned Allegheny County caseworker was on leave. The casework supervisor was covering the absent caseworkers caseload. The team recommended that ACOCYF reinforce policies related to timelines for face-to-face visitation with children. It was also recommended that the agency temporarily reassign cases to an identified caseworker when the assigned caseworker is on leave for an extended duration.

In addition, the team suggested that more conversations need to occur regarding the challenges of court ordered placements in uncertified homes [redacted] Allegheny County Children, Youth and Family Services will review the appeal process with the courts.

Recommendations for Change at the State Level: None provided.

Department Review of County Internal Report:

The Western Regional Office of Children, Youth and Families reviewed Allegheny County Children, Youth and Family Services report on December, 27, 2013.

Department of Public Welfare Findings:

County Strengths: The Act 33 Child Fatality Review Team convened within 30 days of April 4, 2013. Referrals were made for in-home services to [redacted] The child's mother was encouraged [redacted] and to continue to remain involved in the services being provided by the [redacted]

County Weaknesses: No home visits occurred from November 9, 2012 to January 30, 2013 while the assigned Allegheny County caseworker was on leave. The casework supervisor was covering the absent caseworkers caseload.

There is no documentation of a safety assessment being completed at the child's mother's home from the time [redacted] had made a report of the children being in the maternal uncle's care due to the mother's home being dirty, having no utilities and her drug use. In addition, no safety assessment was completed the time the child's mother took [redacted] home after [redacted] the hospital.

Statutory and Regulatory Areas of Non-Compliance:

Allegheny County Office of Children, Youth and Families will be receiving a regulatory citation for not seeing the children on a monthly basis face-to-face which is in accordance with regulation 3490.61 (a).

Department of Public Welfare Recommendations:

Allegheny County Children, Youth and Family Services should review the appeal process with courts [redacted].

Allegheny County Children, Youth and Family Services should review the agency's oversight and monitoring of uncertified homes.

It is recommended that Allegheny County Children, Youth and Family Services review the agency's protocol for case reassignments when the assigned worker is on extended leave.

In addition it is recommended that the Allegheny County Department of Human Services ensures that when children are placed into agency custody that the child's medical cards are provider to the caretaker as soon as possible.