pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Jamal Brown

Date of Birth: 10/10/2012
Date of Death: 04/15/2013
Date of Oral Report: 04/12/2013

FAMILY KNOWN TO:

Beaver County Children and Youth Services

REPORT FINALIZED ON: 02/03/2014

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. Beaver County Children and Youth Services has not convened a review team in accordance with Act 33 of 2008 related to this report, as they designated the report as [redacted] within 30 days of the report.

Family Constellation:

Name:	Relationship:	Date of Birth:
Jamal Brown	Subject Child	10/10/2012
[redacted]	Sister	[redacted]2011
[redacted]	Brother	[redacted]2010
[redacted]	Sister	[redacted]2008
[redacted]	Mother	[redacted]1989
[redacted]	Father	[redacted]1988

Notification of Child Fatality:

The Department was first made aware of the incident on April 12, 2013 after the child presented to [redacted] after being found unresponsive on the family's couch. The incident had occurred sometime in the early morning hours of April 12, 2013. A report was made to [redacted] on this day; subsequently Beaver County was provided with a [redacted] report and the Western Region was made aware of the near fatality as well. The report was initially registered as a near fatality because the child was still alive. However, on April 15, 2013 the child succumbed to his injuries and passed away.

Summary of DPW Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families was able to access all of the necessary documents via Beaver County's web-based case management system (CAPS). The electronic file was reviewed, including structured case notes, safety assessments, and risk assessments.

In addition to the file review, a discussion with the Intake Supervisor took place on December 5, 2013 to obtain the most up-to-date information on the case.

Because the subject child's death was determined to have been accidental and a [redacted] was completed within 30 days with [redacted], the agency did not conduct a child fatality review team meeting or complete a fatality report.

Children and Youth Involvement Prior to Incident:

Beaver County Children and Youth Services (CYS) had been previously involved with this family from October 15, 2012 until December 13, 2012. The allegations involved possible [redacted] by the paternal grandfather, who had been residing in the home at the time. In addition, the family was reportedly having difficulty maintaining acceptable housing conditions.

The agency conducted an assessment, which included a risk assessment, and both preliminary and conclusion of assessment/investigation safety assessments. [redacted]

[redacted]

Prior to closing their involvement with the family, CYS referred the parents for a [redacted] the agency terminated their involvement with the family on December 13, 2012.

Circumstances of Child Fatality and Related Case Activity:

At 6:20 AM on April 12, 2013, Beaver Co. CYS received a report of [redacted] with Jamal as the alleged victim. According to the initial report, the father was sleeping on the couch with 6-month-old Jamal and Jamal's sister, who was 18 months old at the time of the incident. The mother couldn't see Jamal. When asked where he was, the father said he didn't know. The child was then found unresponsive underneath the 18 month old sibling. Upon receipt of the report the agency immediately took action to initiate an investigation.

The on-call caseworker contacted [redacted] and spoke with a social worker, who advised the worker that the parents were not at the hospital with the child as they were waiting for a ride. The child was not expected to survive the morning.

The on-call caseworker then contacted the [redacted] Police Department and spoke with the officer that took the initial call. According to the officer, the mother reportedly came home and found the father and children were on the couch. The mother woke the father because she couldn't see Jamal. After waking the father, she noticed one of Jamal's legs underneath his 18 month old sister. The parents contacted 911. The police and EMS responded. When the police arrived on scene, the child's grandmother was already there performing CPR on Jamal. The child was transported via ambulance to Heritage Valley Hospital in Beaver and later transferred to

CHP. The officer also advised the worker that he felt the family home was in "deplorable" conditions and there were no beds in the home. A codes enforcement officer was going to visit the home later in the morning. The police were unsure if there was electricity to the second floor.

The caseworker then spoke briefly with the mother, who stated they were waiting for a ride to the hospital to be with their child. The other children were with them. The worker advised the mother that until the agency could complete an investigation, the children would need to stay with someone else or someone would have to be with them while they cared for their children. The worker advised the mother that she would be there for a brief visit and that the mother was to locate a resource to care for the children and inform the worker of who would be doing so. A few minutes later, the mother called the worker and provided her with names and addresses of family members where the other children would be staying.

The on-call worker met the assigned intake worker at the family home to ensure the safety of the children and assess the living environment. The children were seen and then sent with the family members designated to care for them. The Codes Enforcement officer arrived and inspected the home, as did the caseworker and [redacted] Police. There were no beds observed in the home, however, they did observe a mattress on the floor in a room that was locked from the inside with a deadbolt. Although the caseworker documented in the case note that the house was above minimal standards, the codes officer condemned the house because of the deadbolt lock on a bedroom door (which was described as illegal), a loose handrail, and mostly sanitation reasons. The family was no longer permitted to sleep at that residence.

The caseworker obtained all of the necessary information to obtain emergency clearances on the persons identified to provide temporary care for the children in this family.

The caseworker then responded to the hospital to meet with the family members. The mother provided her with her version of what happened. She had left the home at approximately 11 PM to go visit a friend. When she left, Jamal was sleeping on the couch, the other children were awake and sitting on the floor, and the father was "cleaning up." She returned after 1 AM and that's when she discovered Jamal underneath his sister. Neither parent is on any medication. Both parents receive [redacted]. The mother reported that the family has beds in the room that was locked, including a bassinet for Jamal.

The father was interviewed and told the caseworker his account of the prior night. He reported the mother leaving the home after 10 PM. He and the older children were watching movies and Jamal had fallen asleep on the couch, lying on his back. He turned the movie off around 11:30 PM and the father and two of the older children sat down on the couch. The second youngest child (the 18 month old) was sitting on the floor, so he picked her up and placed her on his chest. He believes they must have fallen asleep shortly after, because the next thing he remembers is the mother waking him up and telling him that the 18 month old child was on top of Jamal. They called 911 and his mother. His mother came and gave CPR until EMS arrived. The father was also questioned about beds in the home and his response mirrored the mother's. They were not sleeping in the bedroom that evening due to a bee in the room, which the parents were worried would sting one of the children.

The worker met with hospital staff, who informed her that the child [redacted] The medical professionals stated they had this discussion with the parents, [redacted]. The caseworker developed a safety plan for the remaining children with the parents and obtained their agreement via signatures. The children would temporarily reside with the family members previously identified and cleared through [redacted].

On April 15th, the caseworker contacted [redacted] to get an update on the child's status. They had attempted to remove him from [redacted] to see if he would breathe on his own, but he wasn't able to. The staff began [redacted].

The worker also spoke with the family, who informed her that they were being evicted from their home and had to be out within five days. They had no place to go. [redacted]

The caseworker was notified by the hospital social worker on April 16th that Jamal passed away on April 15th at 5:45 PM and a skeletal survey would be completed to rule out any other injuries. The results of the survey were provided to the agency on April 17th. There were no acute, past, or present fractures to the child. Based on the survey, there was no indication of [redacted]. In addition, the worker made a collateral contact to the child's pediatrician, who confirmed that the child was in good health, up to date on his shots, and last seen on March 7th for a routine checkup.

Based on the information provided by the medical professionals, the agency determined that the child's death was not as a result of child [redacted] and [redacted] investigation on April 18th. The family was also able to move into [redacted] this day. Because the death was ruled accidental, the agency lifted the safety plan and the children were reunited with their parents.

The family was [redacted] on April 19th because the family was homeless and currently residing in [redacted] due to being evicted for living conditions. In addition, the parents have some [redacted]. The children were also referred for [redacted]

Over the course of the case, the agency was made aware that the mother was once again expecting a child, due in February 2014.

According to the case notes, the agency made a commitment to seeing these children weekly, [redacted] The family's [redacted] was reviewed in October 2013 [redacted]

Current Case Status:

In the most recent contact documented on January 9, 2014, it appears as though the family has located their own housing and was in the process of transitioning from one home to the other. Also, the case note showed that the caseworker reiterated to the family that their case will remain open with the agency due to continued concerns for housing and parenting deficits.

The agency has been negotiating with the family to conduct a Family Group Decision Making meeting to address the housing issues, as well as help alleviate some of the parenting deficits. The oldest child is enrolled in public school and the youngest have been assessed through [redacted] A [redacted] program was also being explored for the middle child, but at this point has not started. The children have been seen by their pediatrician on a regular basis and the parents' history shows a good likelihood that they will continue to meet their children's medical needs.

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

The county did not conduct a review. The child's death was determined to be accidental and the agency completed its investigation within days of the initial report. As such, they were not required to complete one.

Department Review of County Internal Report:

As stated above, no internal report was completed.

Department of Public Welfare Findings:

- County Strengths:

  - The agency handled the investigation very well from the initial call through the acceptance of the case. The on-call caseworker made immediate contact with a supervisor to advise him of the situation and get guidance on how to proceed. Prior to contact with the family, the worker gathered information from the hospital and then contacted the appropriate police department to initiate a joint investigation. The on-call worker and assigned intake worker also met at the family home to discuss what had transpired, assess the safety of the other children, and plan for how to proceed.

  - When gathering information about the incident, the investigating worker asked effective questions and asked follow-up questions for further detail and/or clarification. This information was also well documented in the structured case notes.

  - In addition, the investigating worker made collateral contacts to obtain more information to help make a determination on not only the investigation, but whether or not to accept the family for ongoing services.

- The investigation was done very timely. As soon as the agency had information to make and support a determination, they submitted the report with an [redacted] within days of the child passing away.

- The agency utilized informal supports, such as family members, to ensure safety. This allowed the children to remain in their parents' custody throughout the investigation. In addition, the prompt determination helped reunite the children back with their parents very quickly, causing minimal disruption.

- The agency assisted the family [redacted] when they were evicted and also helped them locate a new residence of their own.

- [redacted] The caseworkers involved in the case made a commitment to seeing the children and family on a weekly basis, sometimes more than once per week, to help ensure the safety of the children in the home.

- The agency ensured that any services that were necessary and/or beneficial for the family were provided, including [redacted] assessments, Family Group Decision Making, and [redacted] for the non-school age children.

- <u>County Weaknesses:</u>

  - Although the structured case notes were completed in CAPS before the completion of this document, the Department had to initially contact the agency to inquire about contacts. The casework supervisor informed this writer that many contacts had not been converted from the worker's handwritten notes to CAPS. This writer provided the casework supervisor with a deadline to have the contacts entered. To their credit, the casework supervisor and caseworker worked diligently to ensure the contacts were entered in the time given. Although this isn't a regulatory citation, it is an area of weakness identified. It also appears as though this weakness may be worker specific and not an agency-wide systemic issue.

  - For this incident, four safety assessments were completed: Preliminary, New Information, Conclusion of Investigation, and FSP/CPP Review.
    [redacted] The Preliminary assessment, dated April 12, 2013, [redacted]

    - The investigating worker completed an assessment on April 18th at the Conclusion of Investigation, determining the children to be safe with the parents, as the report was [redacted] (On this day, the case was accepted for service.)

    - The New Information assessment was completed by the newly assigned ongoing caseworker when the children returned home to the parents. This assessment listed a child not seen as "Jamal Brown." The justification provided was "Child [redacted] at

[redacted] Safety assessment of new home." This assessment was dated April 18, 2013. In a case note dated April 17th, it said that the family wasn't able to move in the home until "tomorrow afternoon," which would be April 18th. The issue with this assessment is that Jamal Brown had passed away on April 15th. This assessment, completed three days later, still listed him [redacted], when he had in fact passed away three days prior to the worker even beginning this.

- Another Safety Assessment was completed by the ongoing caseworker and labeled "FSP/CPP Review Hearing." There are two issues noted with this assessment. The first issue is that the structured case note shows a FSP review occurred in October 2013, two months prior to the completion of this assessment. The second issue is that this Safety Assessment worksheet still contains the language about Jamal being [redacted] at CHP, eight months after his death.

- The last two Safety Assessments completed on the case were reviewed by the ongoing worker's supervisor.

- Statutory and Regulatory Areas of Non-Compliance:

Although the issues identified above are areas of non-compliance, this writer does not believe them egregious enough for citations. They appear to be more errors in oversight and attention to detail, which will be discussed below.

Department of Public Welfare Recommendations:

1. The most significant recommendation to be made involves the thorough assessment of the parents' ability to properly care for and supervise a newborn baby given the history. Particular attention should be paid to the sleeping arrangements and nap times, the parents must be educated on the dangers of co-sleeping, considering one child has already perished from improper sleeping arrangements.

2. [redacted] are reflective of the current status of the case. Supervisors also need to be vigilant in reading what they are approving, as illustrated by the oversight observed in the review of the case record; i.e., a worker prepared safety assessments and a supervisor approved them when a child listed as being [redacted] had already passed away (eight months prior on one).