



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE Fatality OF:

Kylee Davisson

BORN: 01/13/14
DATE OF FATALITY: 05/12/14
DATE OF ORAL REPORT: 05/19/14

FAMILY WAS KNOWN TO:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:

June 24, 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, 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:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Kylee Davisson	Victim Child	01/13/2014
[REDACTED]	Sibling	[REDACTED]/2010
[REDACTED]	Sibling	[REDACTED]/2011
[REDACTED]**	Mother	[REDACTED]/1988
	Maternal Great Aunt	unknown

**Maternal Great Aunt was not a household member at time of the incident; the family does live with her in [REDACTED].

Notification of Child Fatality:

On May 12, 2014 [REDACTED] called Allegheny County Children and Youth (ACCYF) and reported that the mother came into the emergency room with two children for anxiety. [REDACTED] felt mother was very disconnected with the children and very irritable. [REDACTED] Police interviewed mother and maternal aunt. This report was screened out on May 15, 2014.

On May 19, 2014 ACCYF learned of the fatality of the child [REDACTED]. The reporting source [REDACTED] was an anonymous female. Reporting Source stated that the mother told her she was sleeping with the child and "rolled on top of her". The reporting source also indicated that mother was intoxicated at the time. Mother told the hospital the two-year old sister pulled the baby off the bed and the baby banged her head off the floor. Mother did not take the baby for medical attention after the incident due to the baby acting normal. The mother and the surviving children returned to [REDACTED] immediately upon the child's death.

Summary of DHS Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the family. Conversations were held between the ACCYF caseworker and the Western Region Office Children, Youth and Families (WROCYF) Regional HSPR on several occasions. The regional office participated in the Act 33 Meeting on July 17, 2014.

Children and Youth Involvement prior to Incident:

The family first became known to ACCYF in 2011. The family relocated from ██████████ County, ██████████ to Allegheny County. ██████████ County Department of Human Services alerted Allegheny County CYF to the on-going substance use by mother and father. They were not accepted for service, due to the family moving back to ██████████ ██████████. There were no face to face contacts made.

The ██████████ family does have a significant history in ██████████.

Circumstances of Child Fatality and Related Case Activity:

On 05/19/14, this case became known to both ACCYF and WROCYF. The mother and the surviving children returned to ██████████ the day of the baby's death on 5/12/14. On 06/09/14, ██████████ interviewed the mother. They did not give ACCYF a copy of their interview. The autopsy on the child was done by the Allegheny County Medical Examiner's office the results were inconclusive. The ruling of death by the Medical Examiner's office is Sudden Unexplained Infant Death (SUID).

On 06/17/14 ██████████ was filed with Childline. The report was ██████████. The investigation did not reveal substantial evidence of serious physical injury caused by the acts or omission of acts by the alleged perpetrator.

Current Case Status:

The family is currently living in ██████████. No charges are or will be filed in Pennsylvania in regards to this case. The family is opened with ██████████ County CYS. Children were placed in foster care on 06/24/14 due to the mother facing charges of child neglect in ██████████. Father was incarcerated in ██████████ on a parole violation.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child 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 on July 17, 2014.

- Strengths: Past history with family demonstrated their willingness to work with services; intermittent treatment for substance abuse.
- Deficiencies: Chronic poly-substance abuse by parents; father incarcerated; mother has an outstanding warrant.
- Recommendations for Change at the Local Level: N/A
- Recommendations for Change at the State Level: The state should explore in acting legislation to criminally charge mothers if they choose to use drugs while pregnant,

Department Review of County Internal Report:

Since the ACCYF completed their investigation within 30 days of receipt of the oral report they were not required to submit an internal report.

Department of Human Services Findings:

- County Strengths: ACCYF held an Act 33 Child fatality Review Team meeting even though they were not required due to the [REDACTED] report being [REDACTED] within 30 days.
- County Weaknesses: [REDACTED] Police Department did not provide ACCYF with a copy of their interview with the mother even though ACCYF requested it multiple times.
- Statutory and Regulatory Areas of Non-Compliance: N/A

Department of Human Services Recommendations:

- The Department recommends ACCYF review their policy on receiving and processing ChildLine reports about families moving from other states.
- Allegheny County needs to review and reinforce their established joint investigative protocol that was developed by the Office of the District Attorney, Law Enforcement and ACCYF.