



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**REPORT ON THE FATALITY OF:**

**Nevaeh Andiorio**

**DATE OF BIRTH: December 5, 2012**

**DATE OF FATALITY: June 17, 2014**

**DATE OF ORAL REPORT: June 18, 2014**

**FAMILY KNOWN TO:**

**Allegheny County Department of Human Services  
Office of Children, Youth and Families**

**REPORT FINALIZED ON:**

**March 23, 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:**

**Child's Household:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Nevaeh Andiorio	Child	12/6/12
[REDACTED]	Maternal Great-Aunt	Unknown
[REDACTED]	Maternal Aunt	Unknown

**Mother's Household:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	[REDACTED]/89
[REDACTED]	Mother's Paramour	[REDACTED]/51

**Case Significant Non-Household Members:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Father	[REDACTED]/77
[REDACTED]	Maternal grandfather	[REDACTED]/59
[REDACTED]	Half Sibling	[REDACTED]/08

**Notification of Child Fatality:**

Allegheny County Children, Youth and Families (CYF) received a [REDACTED] report on June 18, 2014. The report identified that the subject child had died the previous evening of June 17, 2014 after transport to the Children's Hospital in Pittsburgh. The report was being made due to the death being unexpected and unexplained. The child had no signs of trauma and [REDACTED] skeletal survey were negative [REDACTED]

According to reports, the child was found unresponsive by the mother while they were staying at the mother's paramour's home. The mother had attempted to awaken the child

by dousing her with water and then called emergency services. Police and medical units were dispatched to the home of the mother's paramour for the child, who was reportedly not breathing. When the initial police unit arrived, the fire unit was already performing CPR on the child. She was pronounced deceased at the emergency room when CPR was determined to be unsuccessful. The report was subsequently registered as a child fatality on June 18, 2014. The cause of death was still being determined; [REDACTED]

#### **Summary of DPW Child Fatality Review Activities:**

The Western Region Office of Children, Youth, and Families reviewed current and past case documentation and reports provided by Allegheny County CYF regarding the status of the case. The regional office also participated in the County Internal Fatality Review Team meetings on July 10, 2014 and on August 21, 2014

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

Allegheny County had a prior intake history with the family, starting in 2008. The following is a brief summary of the details to the prior referrals.

##### August 2008

The county received a report indicating that the mother gave birth to a newborn [REDACTED] exposed to [REDACTED]

There were no concerns expressed with the mother's ability to parent the newborn. The mother had discovered in February 2008 that she was pregnant [REDACTED] [REDACTED] The referral was closed at intake in September 2008.

##### February 2009

The county received a report that the father had been arrested and placed in jail. The referral stated that the father would put the child in "harm's way" when he is released to house arrest. The referral was screened out as there were no allegations of safety/risk noted in the referral.

##### November 2010

The county received a referral alleging that the mother had wrecked a car she borrowed from a male acquaintance. The report indicated that the owner of the automobile assaulted the mother and the child. The alleged perpetrator (AP) had hit the child on his head with a cell phone, resulting in a lump on his head. The child also had abrasions on his arms and legs from being grabbed by the AP. The child was examined by physician. The child did not have any diagnosed injuries. The AP was arrested and placed into custody. The case was provided with a FGDM conference and the Maternal Grandfather was chosen to care for [REDACTED] The case was accepted for services in January 2011 for parental substance abuse. The child remained in the custody of his grandfather and the case was closed in August 2011.

April 2012

The agency received a referral that the mother was "living" in the grandfather's home with her son, who had remained in the custody of the grandfather. The mother was allegedly still using drugs. The child remained in the safety of his grandfather and with no specific allegations to safety, the referral was screened out.

October 2012

The agency received a referral that the child was again living with the mother. The report alleged that the mother was addicted to heroin and using 20 bags a day. The child was allegedly outside unsupervised often "because the mother was high". The father was also living in the home and was reportedly using marijuana. The field screener went to the home and did not find any evidence to the allegations and screened out the report.

December 2012

Allegheny County CYF received a report that the mother had given birth to a newborn (Nevaeh) who tested positive for [REDACTED]. The mother had admitted to the reporting source that she was using 4-6 bags of IV Heroin a day throughout her pregnancy. The case was closed on January 11, 2013 due to the father being the primary caregiver to the child and the sibling being returned to the maternal grandfather's custody. The case was closed under the agreement with the father and grandfather would not allow the mother to have unsupervised contact with the baby.

#### **PRIOR INVOLVMENT WITH BIOLOGICAL FATHER:**

Allegheny County had past involvement with the child's father when he was married to another woman. The following is a brief summary of that involvement.

October 2007

The agency received a report that the mother of [REDACTED] other children had overdosed. The father [REDACTED] was seeking to care for the children. The case was accepted for services in December 2007, with services being provided until closure in April 2008.

October 2008

Allegheny CYF received a report that a passerby had seen a small child run into the street. The police had responded to find that the babysitter had fallen asleep and the child had gotten out of the house. The father was working at the time. The child was assessed to be safe and the report was screened out.

March 2009

The agency received a report that the father's home was "raided" in a drug raid. The child was living primarily with his mother out of state and was visiting with his father every other weekend. The information was vague and gave no allegations of abuse. The father had been incarcerated in February 2008-February 2009 for drug related charges. The referral was screened out.

**PRIOR INVOLVMENT WITH MOTHER AS A YOUTH:**

The mother had a history with Allegheny County as a youth. There were thirteen referrals between the years of 1992-2005. The majority of these referrals involved the lack of supervision and parental substance abuse by the child's mother.

**Circumstances of Child Fatality and Related Case Activity:**

On June 18, 2014, the report was registered [REDACTED] as an official child fatality report due to lab results showing that the child had tested positive for opiates at the time of her death. Follow up interviews documented that the child had been in the care of her biological father until his arrest. The child was then being cared for by multiple family members (maternal grandfather, maternal grandmother and maternal step-aunt). The grandfather reported that he was at the hospital with his ill son on the day of the incident. The child was being cared for by the maternal step-aunt. The aunt knew the grandfather did not want the mother to visit the child unsupervised; however, she allowed the child to go with the mother "for a couple of hours". The mother took the child to her paramour's home.

As per the report, prior to the mother's arrival to the paramour's home the mother had ingested three stamp bags of heroin. Later that afternoon, at approximately 6:30 pm, the mother lay down with the child in the only bedroom in the home. The mother was awakened around 8:30 pm by her paramour to see if she wanted dinner. The mother awoke and stated that she noticed her child was unresponsive and her lips were blue. After telling the paramour to call 911, the mother then ran into the bathroom to douse the child with water. The paramour then asked the mother where his [REDACTED] was that he had left on the end table beside the bed. The mother reported that her paramour was more concerned about finding his [REDACTED] as he believed that the child might have ingested it and did not call 911. The mother then called emergency services and the fire and EMS departments responded. The child was transported to Children's Hospital in Pittsburgh [REDACTED]

[REDACTED] the mother admitted to using heroin prior to arriving at her paramour's residence. Mother also admitted to stashing four bags of heroin and a needle close to the bed in the room where her child was sleeping. A urine test at the child's autopsy revealed the child was positive for the presence of opiates.

Immediate attempts were made on June 18, 2014 to locate the child's sibling, who was in the legal custody of the grandfather. The sibling had been staying with his maternal great-aunt since January 2014 due to the grandfather caring for his ill son. Contact was made with the maternal great-aunt and it was reported that the child was staying with a cousin in Washington County for a few days. Washington County CYS completed a courtesy assessment of the child at the cousin's home and an appointment was scheduled with the great-aunt to see the child upon his return to Allegheny County on June 20, 2014. At the time of the scheduled visit, the child's safety was assured and it was

reported that the family does not and would not allow any unsupervised contact between the mother and child's sibling.

On June 19, 2014, autopsy results showed the child had opiates in her system and nothing but mucus in her stomach. The child had either ingested heroin or [REDACTED]. The mother and paramour were both charged with Endangering the Welfare of a Child and Involuntary Manslaughter. Additionally, the mother was charged with possession of heroin.

The mother was interviewed [REDACTED]. She confirmed most of the details from the initial reports. She reports that the subject child had been living with the child's father prior to his arrest, but stayed with her frequently. The mother reported that the child was up to date on her immunizations and denied any medical conditions. The mother had asked the maternal aunt to care for the child so mother could "get back on her feet". The mother admitted to using heroin for the past several years and [REDACTED]. The mother admitted that while she and the child were in the paramour's home, there were both heroin and [REDACTED] in the room where she and the child slept.

The child's father was interviewed [REDACTED]. The father reported that he was arrested in May 2014 after a car accident. He had been driving on a suspended license when he caused the accident, injuring another person. Father was sentenced to finish out his parole in prison, which was to max out in October 2014. The father denied any recent use of illegal substances and had been clean for all of his screens through parole.

It was determined that the child's death was due to an overdose of [REDACTED] and on August 15, 2014 Allegheny County CYF [REDACTED]. The mother and paramour were both charged in the death of the child.

#### **Current Case Status:**

The referral was closed at the submission of [REDACTED] report. The surviving sibling remained in the legal custody of his maternal grandfather and no concerns were raised regarding this arrangement. The grandfather appeared to be providing for the child's emotional needs following the death of his sister.

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

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- Strengths:
  - The Act 33 Review Team identified no statutory or regulatory compliance issues.
  - CYF responded immediately to the fatality report, conducted a thorough investigation and ensured the safety of the child's sibling by requesting a courtesy interview of the child and assessing his safety.
  
- Deficiencies:
  - The Act 33 Review Team identified no deficiencies with the fatality investigation.
  
- Recommendations for Change at the Local Level:
  - The Review Team recommends that CYF develop a safe case closure protocol that will establish guidelines to help ensure child safety prior to closure. This should include guidance on the length and type of monitoring that should be completed for any safety plan(s) prior to closure. This may be included as a part of the "Safety Academy" currently under development.
  - The Review Team recommends that CYF review and revise policy, procedures and training regarding the Safety Assessment Management Process. CYF is noted to be developing a "Safety Academy" to reinforce those procedures.
  - The Review Team identified need for improvements in CYF's assessment and understanding of domestic violence and of behavior health challenges and the impacts on children, with focus on the need for comprehensive assessment and planning with all caregivers.
  - The Review Team recommends reinforcement of current state of practice related to use of data systems for the purpose of case assessment, case planning and family finding.
  - The Review Team recommends the development of decision support tool to trigger administrative review for case acceptance and enhanced service coordination in regards to families with multiple referrals within a specified time.
  - The Review Team recommends a review and reinforcement of the established joint investigative protocol developed by the Office of the District Attorney, law enforcement and CYF.
  
- Recommendations for Change at the State Level: No recommendations for change at the state level were noted during the Act 33 Review meeting.

#### **Department Review of County Internal Report:**

The Department has reviewed the Act 33 Review Report and is in agreement with the recommendations made in the report.

**Department of Public Welfare Findings:**

- **County Strengths:**
  - Allegheny County CYF collaborates well with local partners, such as the Child Advocacy Centers, local law enforcement agencies, and the District Attorney's Office.
  - The Act 33 Review Team consists of various committed disciplines who routinely meet to discuss case activity. There is representation from the medical field, Child Advocacy Centers, Law Enforcement, District Attorney's Office, and multiple CYF and DHS personnel.
  
- **County Weaknesses:**
  - Due to the history of the family, particularly the mother and father's extensive drug and alcohol histories and domestic violence issues, concerns surface as to the county's decision making practice in case closure. In particular, the closure of the report following the birth of the victim child.
  - The case history lacked a thorough assessment of the mother's drug and alcohol issues.
  
- **Statutory and Regulatory Areas of Non-Compliance:**

No areas of non-compliance with regards to specific regulation or law.

**Department of Public Welfare Recommendations:**

No additional recommendations or areas of improvement at this time. The recommendations given by the review team are sufficient recommendations to address the concerns noted above.