



## **REPORT ON THE FATALITY OF:**

Tie'a (Tieairee) Henderson-Martinez

**Date of Birth: 12/04/2013**

**Date of Death: 02/09/2015**

**Date of Report to ChildLine: 02/26/2015**

**FAMILY NOT KNOWN TO COUNTY CHILD WELFARE AT THE OF INCIDENT OR  
WITHIN PRECEDING 16 MONTHS:**

**Erie County Office of Children and Youth**

**REPORT FINALIZED ON:**

8/6/15

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. Section 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, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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 fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine. Erie County Office of Children and Youth has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 03/24/2015.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Tie'a Henderson-Martinez	Victim Child	12/04/2013
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Biological Mother	[REDACTED] 1995
[REDACTED]	Mother's Paramour	[REDACTED] 1986
* [REDACTED]	Biological Father of Victim Child	[REDACTED] 1992
* [REDACTED]	Biological Father of Sibling	[REDACTED] 1995
[REDACTED]	Maternal Uncle	[REDACTED] 1993
* [REDACTED]	Maternal Grandmother	[REDACTED] 1977
* [REDACTED]	Maternal Grandmother's Paramour	[REDACTED] 1971
* [REDACTED]	Maternal Uncle	[REDACTED] 2015
* [REDACTED]	Maternal Aunt	[REDACTED] 2009

\*Not a household member at the time of the incident.

**Summary of OCYF Child Fatality Review Activities:**

The Western Region Office of Children, Youth and Families (WRO) obtained and reviewed all current and past case records pertaining to the [REDACTED] family. WRO conducted interviews with the Intake Caseworker, and Supervisor on 03/17/2015, as well as had on-going communication with the Intake Manager. WRO staff actively participated in the Act 33 meeting that occurred on 03/24/2015 in which agency staff, other Department of Human Service agency staff, the Director of the Child Advocacy Center, and the agency attorney attended. Information regarding previous involvement and the current investigation was provided for review prior to the meeting, and it was presented and discussed at the meeting. WRO also interviewed the on-going supervisor on 07/09/2015.

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

There was a previous General Protective Services (GPS) report referred on 09/12/2012, alleging that the mother grabbed the sibling and then slapped her across the face. The reporting source also stated that she has seen the mother do things like this in the past. The sibling was 9 months old at the time, and the mother and child were living with the maternal grandmother. At the initial contact, the child had no injuries and the mother and maternal grandmother denied the allegations. The child presented as being well cared for which collateral contacts corroborated. The GPS referral was closed on 10/08/2012.

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

The Erie County Office of Children and Youth Solicitor received a call on 02/26/2015 from [REDACTED] in regards to the death of 14 month old Tie'a Henderson. The victim child died on 02/09/2015 and on 02/26/2015 the toxicology results showed that the child had 320 Nano grams of heroin in her system; as well as an appropriate level of [REDACTED]. The victim child died of a heroin overdose. A [REDACTED] report was also generated regarding the family at that time. The report also stated that the maternal family does not like the mother's paramour and allegedly a gun was pulled at the victim child's funeral and other family members intervened. Information was provided regarding the mother's paramour; she is awaiting charges on heroin delivery from last summer. She pled guilty to the charges on 03/18/2015 and was sentenced to 9 to 23 months at SCI [REDACTED].

[REDACTED] also provided the following details: On 02/09/2015, the victim child was noticed to be unresponsive at the home at 7:16am by the mother and her paramour. 911 was contacted at 7:16am and arrived at 7:21am, finding the victim child unresponsive. The official time of death was determined at University of Pittsburgh Medical Center, Hamot Hospital at 7:50am. At the time of admission to the hospital, there were no immediate concerns or red flags of child abuse as the victim child presented with no trauma to her body or track marks. It is still not known how the victim child ingested the heroin. The forensic nurse stated that the victim child would have died immediately from the amount of heroin in her system.

On 02/26/2015, the caseworker responded by meeting with the [REDACTED], the mother and the sibling at a friend's home. [REDACTED] stated that the mother passed the drug screen and that he was on his way [REDACTED] the mother's apartment. Given the circumstances surrounding the victim child's death and the threats identified for the sibling's safety and well-being, the agency [REDACTED]. The sibling was placed in a foster home on 02/26/2015. The mother stated that the sibling's biological father has been incarcerated her entire life, but she has had phone contact with him. The mother reported that her family and the paternal family have a close relationship.

[REDACTED] The caseworker met with the maternal grandmother [REDACTED] to obtain information as she was interested in becoming a kinship caregiver. The caseworker completed a home evaluation/background check of the maternal grandmother's and her paramour's home. At that point, a referral was made to a contracted provider requesting a kinship home study. [REDACTED] also reported on this date that he was getting a court order to obtain the medical records for the victim child. The caseworker met with the sibling in the foster home on this date to do a minimal facts interview. The mother provided information that her paramour is now staying with paramour's mother and that she does not intend to continue living with her.

The agency complied with Fostering Connections as searches were completed and letters were sent to family members. [REDACTED]

[REDACTED] The maternal and paternal relatives have a positive relationship so the sibling does have contact with both families. A safety plan was developed; reviewed and signed by all parties. The mother agreed to supervised visits. The caseworker picked the sibling up from the foster home and took her to the maternal grandmother's home [REDACTED]. The goal for the sibling is reunification with mother. Concurrent goal is adoption.

The mother's paramour did not cooperate with the criminal investigation. [REDACTED] reported that he made efforts to speak to her. The mother's paramour had been arrested on 05/3/2014 for Manufacture, Delivery, or Possession of Heroin with Intent to Manufacture or Deliver. There were other charges which were "Nolle Prossed". On 03/18/2015 she pled guilty to that charge and was sentenced to serve 9-24 months and was sent to SCI [REDACTED]. It is important to note that the paramour has an extensive criminal history dating back to 2004 which include assault, theft and drug related charges.

On 03/17/2015 the service plans were complete with the mother. She agreed to have random urine screens and [REDACTED]; to attend parenting classes; and [REDACTED]. The mother reportedly visits the victim child's grave daily. She visits with the child's sibling two times a week for 2 hours, either at her home or the maternal grandmother's home.

The victim child's biological father [REDACTED] shortly after her death and was [REDACTED]. He was referred [REDACTED] and remains on probation for previous drug related convictions.

On 04/21/2015, the agency completed the [REDACTED] with the outcome of [REDACTED] for victim child's mother and her paramour. The [REDACTED] did not allow Erie County to complete interviews on the mother and her paramour

regarding the incident as the criminal investigation is ongoing. The victim child's Primary Care Physician (PCP) noted no concerns with the medical care she received.

On 04/20/2015, the [REDACTED] stated that he was planning to go to SCI [REDACTED] and transport the mother's paramour back to Erie County for an interview. The body of the victim child had been exhumed and the bottle she was drinking from was sent to the lab; toxicology screens are pending. Allegedly, the paramour had a video of the victim child on her cell phone dated 02/08/2015 at 7pm and the child appeared to be doing well. This was the night before she was found unresponsive.

The sibling continues to do very well in the care of her maternal grandmother and she attends daycare/ preschool Monday-Friday. The mother actively participated in weekly [REDACTED]

[REDACTED] The mother had random urine screens throughout this time period which were negative. [REDACTED] The mother had complied with parenting classes, [REDACTED]; however, there is a concern that she is not able to acknowledge her paramour's involvement with heroin, despite the fact she is currently incarcerated for heroin related charges. The paramour has an extensive criminal history involving assault, weapons, theft/robbery, terroristic threats, and drug related charges dating back to 2004. The mother states that she is no longer in a relationship with the paramour; however, the paramour was described as being very controlling over the mother and there is a concern that she will go back to the relationship once the paramour is discharged from prison.

[REDACTED]

It is important to note that the paramour had been involved in the mother's life prior to the victim child being born. The mother gave the victim child the paramour's last name on the birth certificate. The victim child's biological father continues to struggle with [REDACTED], previous incarcerations, and probation and parole. [REDACTED] had provided information that the victim child's biological father had recently entered into the victim child's life and was requesting contact with her. This caused a strain on the mother and her paramour's relationship.

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

Strengths:

- Quick action of Erie County Office of Children and Youth once the referral was received to establish safety of the sibling in the home.

- Quick action by Erie County Office of Children and Youth to get the sibling placed into a kinship home.
- Good working relationship with DA's office, law enforcement and CAC.
- Meetings are taking place between the hospital and Erie County Office of Children and Youth (OCY) for protocols on child abuse.

Deficiencies:

- The only contact with the family was weeks after the victim child's death as it was not reported until 2/26/2015.
- There was limited contact with the mother regarding the incident due to a pending criminal investigation.
- There was a lack of communication from the hospital in which the victim child was taken on 02/09/2015.
- The forensic medical staff in both Erie hospitals is in flux and changing employees.

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

- Hospitals need to notify OCY of any child deaths. This would be beneficial to both hospitals in Erie and OCY. OCY could be prepared to respond if/when a referral is received.
- If the hospital were to contact OCY at the time of the death/near death, OCY may have information that would be beneficial to law enforcement and hospital staff such as any current/past involvement with the family.
- Law enforcement needs to preserve the crime scene. This is a struggle as emergency service workers are instructed to transport a child immediately no matter what the circumstances.
- Hospitals need to notify OCY immediately after the death/near death. In this case, doing so would have allowed the agency to speak with the mother and obtain pertinent information regarding the circumstances to be able to share with hospital staff as well as law enforcement.
- A preliminary toxicology screen could have been done at the time the victim child was brought into the emergency room for faster results.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

- No recommendations were made.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

- It would be beneficial to locate a physician willing to become part of the fatality/near fatality committee. The physician's knowledge and input would be beneficial in trying to summarize cases and answering questions that only medical personnel could.
- Continue to build bridges with medical personnel on OCY protocol.
- Concurrent planning adoption/kinship for the sibling. Continue to pursue kinship providers on her paternal side of the family.

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

WRO received the Erie County Office of Children and Youth Services Internal Report on 04/24/2015. DHS found the county's internal report as an accurate reflection of the Act 33 meeting. The report contents and findings are representative of what was discussed during the 03/24/2015 meeting. Verbal feedback was provided to the Intake Administrator during subsequent conversations regarding an update on the criminal investigation.

## **Department of Human Services Findings:**

### County Strengths:

- The agency complied with Fostering Connections by locating relatives and providing notification of the sibling's placement. As a result, several paternal relatives came forward and are supporting the sibling's placement with her maternal grandmother.
- The sibling was initially placed in foster care on 02/26/2015 for one day and the agency was able to place her with her maternal-grandmother on 02/27/2015.
- The agency scheduled visitation for the mother and sibling quickly and the first supervised visit was at the maternal grandmother's home on 03/03/2015. The visits at the maternal grandmother's home were announced and unannounced.
- The agency maintained weekly contact with the mother and sibling as well as the maternal grandmother, as visitation was set up to occur twice weekly for 2 hours supervised by the caseworker.
- The agency provided the mother and sibling with referrals for [REDACTED].
- The caseworkers were sensitive to the mother's grief issues and did an excellent job engaging the mother quickly and providing her with the services she needed to assist her in obtaining custody of the sibling.
- The agency made efforts to engage law enforcement regarding the status of the criminal investigation by maintaining regular contact with the assigned detective.

### County Weaknesses:

- The agency's outcome related to the [REDACTED] was deemed to be [REDACTED]. This does not appear to be the most appropriate outcome in this case as the [REDACTED] completed by the agency states that the investigation revealed that the mother and her paramour were in a caretaker role at the time the victim child ingested the heroin. Additionally, given the fact that the mother seems unwilling to acknowledge that her paramour is involved with heroin, even though she has been convicted and is serving a sentence for drug offenses, the agency should have considered the status of the investigation to be [REDACTED] as both caretakers failed to protect the victim child from ingesting heroin which resulted in the child's death.

- The law enforcement officers of Erie County who are assigned the criminal investigations regarding the fatality and near fatality of children do not attend the agency meeting specific to that case.
- There are no medical personnel on the Erie County team to review fatality or near fatality cases.
- Not having law enforcement and medical personnel on the review team is detrimental to the near fatality/fatality team meeting conversation/agenda.
- Documentation on the [REDACTED] and in the on-going dictation states that the mother and her paramour were not interviewed because of the criminal investigation. It is not clear if the Detective requested that the alleged perpetrators not be interviewed, or if this is agency practice when local law enforcement is involved.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:

There are no statutory or regulatory areas of non-compliance identified.

**Department of Human Services Recommendations:**

- If a caregiver is involved in the probation or parole system, and has an extensive history of violence and drug related crimes, there needs to be more efforts on the assigned officer regarding having an awareness of who the caregiver is residing with and if there are children in the home; consideration needs to be made to refer the case to CYS for a GPS investigation to ensure the children's safety.
- Consideration needs to be given when EMS, hospital staff and coroner's are involved in a child's death that a report be made to CYS for a CPS referral if there are obvious signs of abuse/neglect at the time of the child's death. The same consideration should be made for notifying law enforcement. Given the delay in this child's death and the CPS report, evidence could be removed or destroyed that would have been pertinent to the law enforcement investigation.
- Consideration needs to be given to having an on-going public service announcement and or billboards that details the risk and signs of abuse related to infants and small children. The message also needs to encourage parents to have an awareness of whom they choose to live in their home and be a caregiver for their children.
- The agency and the DA's office need to work collaboratively in obtaining coroner's reports once completed.