



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

**Nina Risher**

**Date of Birth: 05/17/2014**  
**Date of Death: 08/17/2015**  
**Date of Report to ChildLine: 08/17/2015**  
**CWIS Referral ID: [REDACTED]**

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

Allegheny County Children, Youth and Families

**REPORT FINALIZED ON:**  
April 18, 2016

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:**

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Allegheny County has not convened a review team in accordance with the Child Protective Services Law related to this report. Allegheny County Children, Youth and Families [REDACTED] within the first 30 days of the investigation and as a result were not required to hold an Act 33 meeting.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Nina Risher	Victim child	05/17/2014
[REDACTED]	Biological mother	[REDACTED] 1992
[REDACTED]	Biological sister	[REDACTED] 2012
[REDACTED]	Biological father	[REDACTED] 1986

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

The Western Region Office of Children, Youth and Families (WRO) interviewed the Allegheny County Children, Youth and Families (CYF) intake and ongoing caseworkers regarding the case. A file review at the Allegheny County CYF North Regional Office occurred on October 27, 2015.

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

Allegheny County CYF had no prior involvement with the family.

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

Allegheny County CYF received [REDACTED] report on 08/17/2015 regarding a 1-year-old child who had been burned in an apartment fire. The incident occurred the prior evening, wherein the victim child had been admitted to the University of Pittsburgh Medical Center (UPMC) Mercy Hospital [REDACTED]

The [REDACTED] report indicated that the victim child, her sister and the mother were at the family home in the late evening hours of 08/16/2015. The mother had lit a small candle which was placed in a small candle holder. The mother reported the candle was sitting on top of her stereo and was out of the reach of the children.

She stated she took the trash out. The mother placed the victim child into a high chair in order to keep her from getting into anything while she ran across the street with the trash. Her other daughter was sitting down eating a snack. She reported that she grabbed her keys and proceeded across the street to throw away the trash. She stated she was gone for less than a minute.

When she returned to the apartment she could not open the door. She stated that the door typically gets stuck and she frequently had to jiggle the lock and sometimes kick the door to get it to open. The mother stated that she had reported this problem with the door to her landlord, but it never got fixed. While the mother was attempting to get into the apartment she noticed smoke coming from the apartment. She reported that several of her neighbors came out and tried to get the door open, but no one was able to open the door. The mother and neighbors were also unable to break open the windows due to them being covered with bars.

██████████ Fire Department was called to the scene and was able to put the fire out. The victim child and her sister were transported to UPMC Mercy Hospital. The victim child passed away on 08/17/2015 as a result of burns and thermal inhalation. Her sister was admitted ██████████ at UPMC Mercy Hospital. The sibling sustained smoke inhalation, but had no external injuries. As per the mother, both children were previously healthy and developmentally appropriate. The sibling ██████████ within one week of the fire. She was seen for follow up at Children's Hospital of Pittsburgh.

The mother expressed self-blame for the tragedy and believed that if she had not placed the victim child in the high chair the child may still be alive. The mother reiterated that she was gone from the apartment for less than a minute before returning. She stated she did not dress properly before going outside and did not even have shoes on her feet. During the incident, the mother contacted the children's father, who came to the scene immediately following her call.

██████████ Police Department was notified of the victim child's death. No charges were filed against the mother as the death was ruled an accident. The victim child sustained a thermal inhalation injury and the manner of death was ruled accidental. It was also reported that she had extensive charring to her body. ██████████ Arson Squad officially ruled the fire was caused by an unattended candle. No further actions were taken.

The ██████ report was ██████████ on 09/15/2015. The county ██████████ report within 30 days due to the victim child's death being ruled accidental. No Act 33 county review meeting was required or held by the county due to the ██████ report being ██████████ within the first 30 days of the ██████ investigation. The family case was open for ongoing services to support the family with the loss of the child and to aid the family in obtaining new housing. Allegheny County CYF in conjunction with the Red Cross obtained housing for the family. The family has moved from emergency housing and is currently living on their own as a family unit. Allegheny County CYF has had several contacts with the family subsequent to this incident

providing [REDACTED] to the family as a result of the fire. At the present time, the ongoing caseworker is planning on closing the case as no further services are needed or requested by the family.

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

Due to the status of the investigation being submitted within 30 days [REDACTED], the county was not required to hold an Act 33 county review meeting. Therefore, no county report was submitted.

- Strengths in compliance with statutes, regulations and services to children and families; No county report was required to be submitted
- Deficiencies in compliance with statutes, regulations and services to children and families; No county report was required to be submitted
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; No county report was required to be submitted
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; No county report was required to be submitted
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. No county report was required to be submitted

**Department Review of County Internal Report:**

No Act 33 county review meeting was required or held by the county due to the [REDACTED] report being [REDACTED] within the first 30 days of the [REDACTED] investigation. Therefore, no county report was submitted.

**Department of Human Services Findings:**

- County Strengths: The county responded and supported the family immediately and provided aid. The county worked closely with the investigating law enforcement entity to determine an outcome.
- County Weaknesses: None
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. No finding of statutory or regulatory non-compliance.

**Department of Human Services Recommendations:**

It is recommended that county child welfare agencies coordinate with local public relations departments to advertise to the community about the dangers of leaving candles lit or any other burning devices unattended in the home.

It is recommended that community outreach involve landlords, [REDACTED] [REDACTED] to express the importance of proper home repair and maintenance for homes with children. The mother reported to her landlord that the door to the apartment would stick to no avail.