



REPORT ON THE FATALITY OF:

Zaymere Davis

Date of Birth: 08/25/2014
Date of Death: 01/26/2015
Date of Report to ChildLine: 01/27/2015
CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Allegheny County Office of Children, Youth and Families

**REPORT FINALIZED ON:
07/06/2015**

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 07/03/2008. The bill became effective on 12/30/2008 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. Allegheny County Office of Children, Youth and Families (ACOCYF) has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 03/16/2015. A Pre-Review meeting was held on 02/26/2015.

Family Constellation:

<u>First and Last Name:</u> <u>(month/date/year):</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Zaymere Davis	Victim Child	08/25/2014
[REDACTED]	Mother	[REDACTED] 1999
[REDACTED]	Maternal Grandmother	[REDACTED] 1971
[REDACTED]	Father	[REDACTED] 2000
[REDACTED]	Paternal Grandmother	[REDACTED] 1981
[REDACTED]	Paternal Aunt	[REDACTED] 2005
[REDACTED]	Paternal Aunt	[REDACTED] 2000
[REDACTED]	Paternal Aunt	[REDACTED] 2011
[REDACTED]	Paternal Great Grandmother	[REDACTED] 1955
[REDACTED]	Paternal Great Grandfather	[REDACTED] 1953

The victim child lived during the week at the mother's residence with the maternal grandmother and on the weekends at the paternal grandparent's home.

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained all current and past records pertaining to the family. The Western Region Office Human Services Program Representative had numerous conversations with the Allegheny County Office of Children, Youth and Families (ACOCYF) caseworker. In addition the Western Region Office Human Services Program Representative attended the Act 33 meeting on March 16, 2015.

Children and Youth Involvement prior to Incident:

There was no involvement with ACOCYF with the victim child prior to this fatality.

Maternal Family Involvement:

In 1993 there were allegations that maternal grandmother locked her children in the bedroom. This report was screened out. In 1998, there were reports of deplorable housing conditions. The case was opened on 12/13/98 and closed 03/05/99. In 2000, the maternal aunt of the victim child presented at school with welt marks. This investigation was closed at intake. In 2004, maternal grandmother asked the victim child's aunt to leave home; she was 14-years-old at the time. The case was opened on 02/06/04 and closed on 06/05/04. No other information was provided to the Western Region Office of Children, Youth and Families concerning these referrals.

Paternal Family Involvement:

In 2012, paternal grandmother left an infant in the front seat of a running car at a [REDACTED]. The family was referred to Family Group Decision Making and the case was closed at intake. In 2014, paternal aunt (14 years old) engaged in consensual sex. This investigation was screened out. No other information was provided to the Western Region Office of Children, Youth and Families concerning these referrals. On January 9, 2015, ACOCYF received a General Protective Services referral on the father due to concerns for truancy. The family was not cooperative with truancy prevention services that were being rendered. The family was still open for services at the time of the victim child's death.

Circumstances of Child Fatality and Related Case Activity:

On 01/26/2015, at around 2:00 PM the victim child was found at the father's home with mother, face down on a leather couch. It appeared that the last check of the infant by any adults was 12 hours prior, around 2:00 AM. The parents remember giving him a bottle around that time. Upon arrival at the father's home, [REDACTED] reported the victim child was on the third floor of the house and according to their report the home was in deplorable condition. [REDACTED] did not feel safe in the home. The victim child was unresponsive. Rigor mortis and lividity had set in. Cardiopulmonary Resuscitation was started by EMS, but was stopped on the way to Children's Hospital of Pittsburgh (CHP). The victim child could not be [REDACTED] could not be started. The supervising physician stopped life-saving efforts while en route to the hospital. The victim child was pronounced dead at CHP on 01/26/2015.

When the ACOCYF caseworker visited the mother's home, there were baby items throughout the home. The mother and maternal grandmother stated that the mother was the primary caregiver to the victim child. The mother stated that she spent most of a day in her room with the baby. Her description of a typical day with the victim child did not seem genuine. She described the victim child as generally happy and stated he did not cry a lot. One area of concern noted by the

On January 26, 2015, the mother returned to the paternal grandmother's residence around 2:00 PM and checked on the victim child. The mother found the victim child deceased. The paternal grandmother said that she did attempt CPR on the victim child but he was cold and stiff. The victim child's stomach and face were red. The paternal grandmother then called 911.

██████████, the parents gave conflicting information during their interviews. The timeline ██████████ put together was that the victim child was placed face down on the sofa at approximately 2:00 AM and was found deceased at 2:00 PM. The Allegheny County Medical Examiner's Office performed an autopsy on 01/27/15. There were no signs of trauma and no cause of death was determined. The medical examiner did express concern that the victim child had been sleeping on a synthetic leather couch and concluded that unsafe sleeping contributed to the victim child's death. The parents were not charged. ACOCYF filed a ██████████ report on 2/25/15 with a ██████████

A case was then opened for the mother as a child on 01/27/2015, due to allegations of truancy and drug usage. In-home services began to work with the family to assist in getting the mother re-enrolled in school and to provide ██████████ to the family.

A case was also was opened on the father as a child. A referral was made to a truancy program for him. The father's family was not cooperating with services.

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

Strengths:

- ACOCYF responded to the referrals in a timely manner.
- ACOCYF was active with the father's family at the time of the incident and was in the process of implementing services to address his truancy. The agency did provide services to the mother and her family after the incident.
- ACOCYF assessed the safety of the father, mother and underage paternal siblings in their respective homes.

Deficiencies:

- No deficiencies were identified.

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

- Improvement in engagement efforts with families. The paternal family did not respond to engagement attempts from ACOCYF. The truancy service provider did not attempt home visits or make any collateral contacts prior to the incident. Professionals were uncertain whether they were permitted to

reach out to informal community supports to connect with the father who reportedly played on a community basketball team.

- Confidentiality begins when a professional relationship commences but one had not been established. Therefore professionals can contact community supports in order to engage a youth.

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

- ACOCYF track compliance of their recommended improvement's through administrative review and internal and external quality assurance processes.

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

- Health care and community service providers refer and ensure linkages of families that are assessed as high risk to competent community service that provide health care for mother and victim child and supports to the family system. Referrals should include consideration of child welfare system involvement for cases involving high risk and or with active safety threats without child protective service involvement.
- Home visitation services as routine referrals for high risk children and families. A community team is seeking to enhance coordination between the existing home visiting programs to establish a clearinghouse of home visiting programs to address the high mortality rates among African American infants and their families.
- There is a need for further discussions with physical health managed care organizations for development of tracking processes for high risk children in the event that there is inadequate physical health care, including frequently missed appointments and immunization lags.
- ACOCYF enhanced collaboration with the family's home school district

Department Review of County Internal Report:

The Western Region Office of Children, Youth and Families received the Allegheny County Child Fatality Team Report on 06/09/2015. DHS finds the county's internal report as an accurate reflection of the Act 33 meeting that was held on 03/16/2015.

Department of Human Services Findings:

County Strengths:

- ACOCYF was in compliance in meeting the timeframes and requirements for the ACT 33 meeting.

- ACOCYF assessed safety for all the children in the paternal family.
- ACOCYF had not received a referral on the mother during her pregnancy or after the birth of the child. The agency was not active with mother and the maternal family at the time of the incident. Once the mother's family was formally referred to the agency a case was opened on them and the agency implemented services to the family.

County Weaknesses:

- ACOCYF Truancy Department did not attempt any home visits or any collateral contacts prior to the incident

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

- There appears to be no regulatory non-compliance areas.

Department of Human Services Recommendations:

DHS offers the following recommendations to practice as a result of the findings in this review:

- ACOCYF should increase their collaboration with the school districts to close service gaps.
- ACOCYF should collaborate and with community hospitals to identify young mothers and families at high risk so that services can be provided to them.