pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Ny'Lah Carter

Date of Birth: 05/08/2016
Date of Incident: 09/29/2016
Date of Report to ChildLine: 09/29/2016
CWIS Referral ID: [redacted]

FAMILY WAS NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY WITHIN THE PRECEDING 16 MONTHS:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:
05/01/2017

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 was not required to convene a review team in accordance with the Child Protective Services Law related to this report. A status determination of the Report of Suspected Abuse was made within 30 days of the report to ChildLine; therefore, a review team was not required. However, ACCYF conducted an Act 33 meeting on 10/24/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Mother	[redacted]1994
	Father	[redacted]1996
Ny'Lah Carter	Victim child	05/08/2016
[redacted]	Brother	[redacted]2015
	Sister	[redacted]2014
	Brother	[redacted]2012
	Maternal Grandmother	[redacted]1976
	Maternal Grandmother's paramour	unknown
[redacted]	Paternal Grandmother of [redacted]	[redacted]1973

Summary of OCYF Child Fatality Review Activities:

The Western Region office of Children, Youth and families (WRO) obtained and reviewed all current and past records pertaining to the family. WRO was notified of the fatality on 09/29/2016. Allegheny County Children, Youth and Families (ACCYF) made a status determination [redacted] within 30 days of the report to ChildLine; therefore, a review team was not required. However, ACCYF conducted an Act 33 meeting on 10/24/2016. WRO attended the meeting.

Children and Youth Involvement prior to Incident:

On 01/05/2010, [redacted] report was received on the mother. When the mother was 15-years-old and at a friend's house, she reported

that she was fondled while at this home. A referral was made to law enforcement and the report [redacted] by ACCYF.

On 04/14/2010, a [redacted] referral was received regarding the mother as a child. [redacted] The maternal grandmother then filed a missing person's report on the mother. [redacted] The family was not accepted for services by the agency.

On 04/24/2010, a [redacted] referral was received and assessed. The allegations were when the mother was 15-years-old, she burned her 5-month-old niece's wrist. The incident was investigated as a [redacted] report and not a [redacted] report. The victim child was seen at Children's Hospital of Pittsburgh (CHP). An on-call team from ACCYF investigated the allegations and closed the case. The family agreed that the alleged perpetrator would not babysit her niece any longer.

On 04/25/2014, [redacted] filed a report regarding the sibling of the victim child of this report regarding lack of preventative care, missing immunizations and no documentation that the sibling was receiving medical care elsewhere. The family was opened for services on 08/28/2014. The case was closed on 05/12/2015 and the family was referred to community services. According to the ACCYF record, there were no documented contacts between 02/27/2015 and 05/06/2015.

Circumstances of Child Fatality and Related Case Activity:

ACCYF received a report of a child fatality in the early evening hours of 09/29/2016. The referral source (RS) reported [redacted] that per the mother's report, the victim child woke up on 09/28/2016 and ate at 8:00 AM. The mother and the victim child then slept on a couch for a while. The mother then moved the victim child to a "swing/bassinet". They both slept for a while longer until the mother awoke to her telephone ringing. She checked on the victim child and found her to be unresponsive. The child's maternal grandmother, who was in the home at the time, attempted cardiopulmonary resuscitation (CPR) while the mother called 911. When the victim child arrived at CHP she was in cardiac arrest. Lifesaving efforts were not successful, and she was declared dead in the emergency department at CHP. A number of tests where completed after the victim child died. [redacted] The victim child had no signs of trauma to her body. Her body was transferred to the Medical Examiner's Office.

[redacted] was the physician who directed that a report be made to ChildLine for suspected abuse. The alleged perpetrator was named as "unknown". [redacted] report is

being made due to the unexplained and unexpected death of a previously healthy infant.

Since the mother has three other children in her care, a night intake caseworker was dispatched to the mother's home to evaluate the immediate safety of the other children. There was no one home at the family address.

During a visit to the mother and maternal grandmother's home on 09/30/2016, the mother provided her account of what happened to the ACCYF caseworker.

On 09/28/2016, the mother reported it was a normal day. The mother woke up, fed the children, and ran in and out of the house driving people around. The mother stated the victim child usually wakes up around 8:00 AM; either on her own or her 4-year-old brother will wake her if she is not up already. The mother reported the victim child gets a bottle, but she has started her on rice cereal, peaches and bananas. The mother stated she just started this practice on 09/28/2016, and prior to this the victim child was only given a bottle. The mother stated she feeds the victim child as soon as the baby wakes up and her 4-year-old normally eats a few hours later, around 10:00 AM.

On 09/28/2016, around 6:00 AM, the mother reported she went to [redacted] pick up the victim child's godmother from work and drove her home. The victim child's godmother worked overnight. The victim child was with the mother during this trip. Once they arrived at the godmother's house, they hung out for a little while and went back to sleep there. They woke up, went back home, got dressed, and then the mother had to go to a [redacted] appointment at 2:15 PM. After [redacted] appointment, the mother and the victim child came back home and the child took a nap. After the victim child's nap, the mother reported, "We went back down to [the godmother's mother's] house". The mother reported they hung out for a few hours and then came home around 9:00 PM.

The mother said she asked the maternal grandmother if she could watch the children because the mother had stomach pain. The maternal grandmother consented and the mother reported she went to [redacted] Hospital to get examined around 11:00 PM. [redacted] She [redacted] around 1:00 AM on 09/29/2016. She went home and hung out in the living room at that time.

The mother reported the victim child's godmother called to let her know that she had to be at work at 8:00 AM and asked for a ride. The mother told her to borrow the car. However, the victim child's godmother would have to drop the mother off at home before leaving for work. The victim child woke up during the call. The mother took the victim child with her to the godmother's house. The maternal grandmother watched the 4-year-old while the mother did this.

Once back home, the mother reported she put the victim child in her "chair" and she fell asleep around 3:30 AM. The mother reported that she dozed in the living

room with the child until the godmother called to ask if the mother was going downtown for an appointment. The victim child's mother said she did not feel like going. Again, the call woke the victim child. This was around 8:30 AM – 9:00 AM. At that time, the maternal grandmother came downstairs, talked to the victim child. The victim child "babbled back". The mother was on the phone for fifteen minutes or so before hanging up. The mother gave the victim child a bottle, and the two of them fell asleep on the couch together.

At 10:00 AM, the mother reported the phone rang again; it was the mother's maternal aunt. The mother went back to sleep briefly before maternal grandmother's paramour left for work. The closing front door woke the mother, so she picked the victim child up, and put her back in her chair. She propped up the bottle with a baby blanket. During the move from couch to chair, the victim child was moving, squirming, stretched, and made small sounds. The mother went back to sleep on the couch until the maternal aunt called again, but the mother did not answer.

The mother reported she then started to mess around with the victim child. She was talking to her as usual, and playing with her feet, which normally elicits a response if the victim child does not respond to the mother's voice. The mother reported that the victim child "normally kicks or something, but she did nothing". The mother moved the baby blanket, and picked the victim child up. She said she realized "she wasn't moving or nothing". The mother yelled for the maternal grandmother, and ran up to maternal grandmother's room to tell her the victim child was not breathing. The maternal grandmother put the child on the bed and started CPR. The first time the victim child blew milk out of her mouth and nose.

In the midst of performing CPR, the maternal grandmother told the mother to call 911. The operator instructed the mother on how to perform CPR. The mother reported she tossed the phone and went outside after it "wasn't working". She reported she was upset and screaming when a police officer responded to the home, ran inside and took over the CPR attempt. The mother reported she does not know what happened after this. She did not go back inside the house. She did not ride in the ambulance, but got a ride in the police car to the hospital.

At the hospital, the mother reported the hospital did routine x-rays and scans. [redacted] However, they could not give her a cause of death. So, she was waiting for the morgue to call her following the autopsy report. The mother said, "I'm her mom. I'm supposed to protect her and I failed". She was emotional throughout the retelling of the incident and broke down.

The mother provided a description of the victim child's "chair". She described it as "like a rocking chair and bassinette, but you can carry it". The homicide detectives took the chair as evidence. The mother stated when she tried to wake the victim child, she was in the same position as the one she had left her in. She does not remember if the blanket was in the baby's mouth or over her face.

The maternal grandmother was also interviewed and provided a similar account of the date of the incident. At 10:00 AM on 09/29/2016, the mother ran into her bedroom shouting, "my baby's not breathing". The victim child was still warm. The maternal grandmother performed CPR on the victim child. Milk was coming out of the victim child's mouth and nose. The maternal grandmother instructed the mother to call 911. The mother was getting instructions from the 911 operator while she performed CPR. The mother got overwhelmed and threw the phone, and went outside. The maternal grandmother picked up the phone and continued CPR until the first responders arrived and took over.

The victim child's mother reported she shares custody of the 1-year-old and 2-year-old siblings with the paternal grandmother of the children. They were not home at the time of the incident. During the home visit on 09/30/2016, the 4-year-old, the 2-year-old, and the 1-year-old were with the one and two-year olds' paternal grandmother. A complete walk through of the home found it to be appropriate with no apparent safety hazards. The paternal grandmother has custody of them during the school year per a family court order dated 07/11/2016, and planned on moving to Georgia.

On 10/24/2016, an Act 33 meeting was held at ACCYF. The medical examiner gave a verbal report to ACCYF. It was reported the death was "not a suspicious death". The cause of death is "death undetermined". They are still waiting on the toxicology report. There was not aspiration in the lungs. [redacted] physician reported the mother did not have prenatal care while pregnant with the victim child. The mother was given a drug screen [redacted] delivery of the victim child. The mother tested positive for [redacted] but the child's results were negative. It was reported the mother was given an [redacted] for pain. On 09/29/2016, the mother received a [redacted] drug screen at CHP. The immediate results were negative. During the assessment, the father of the victim child could not be located. The victim child's PCP was contacted. The victim child was up to date on immunizations and there were no medical concerns noted.

At the Act 33 meeting on 10/24/2016, ACCYF stated that they had filed the [redacted] report with ChildLine with a status of [redacted] on 10/22/2016. ACCYF was not planning on accepting the family for services. [redacted] Police Homicide Division did not plan on filing charges.

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

ACCYF made a status determination within 30 days of the oral report to ChildLine; therefore, a County internal report was not required.

Department Review of County Internal Report:

ACCYF made a status determination within 30 days of the oral report to ChildLine; therefore, a County internal report was not required.

Department of Human Services Findings:

- ACCYF held the Act 33 meeting in a timely manner even though they were not required to under statute. Although a meeting was held, the county did not issue a report, nor were they required.
- ACCYF responded to assessing the safety of the other children in a timely manner.
- ACCYF provided the mother with information for [redacted]
- The mother of the victim child had admitted to co-sleeping with the child. It is unclear if ACCYF has provided the mother with any resources regarding such unsafe behavior.

Department of Human Services Recommendations:

- Public Service Announcements should be made informing the public of safe sleeping arrangements for babies.