pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Naomi Hill

Date of Birth: 09/29/2016
Date of Death: 10/21/2016
Date of Report to ChildLine: 10/21/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:
04/03/2017

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 Office Children, Youth and Families (ACOCYF) was not required to convene a review team in accordance with the Child Protective Services Law related to this report, as the county submitted [redacted] status determination within 30 days of the report date.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Naomi Hill	Victim Child	09/29/2016
[redacted]	Half-brother	[redacted]2009
	Half-brother	2008
	Mother	1985
	Father	1983
*[redacted]	Father of half-brothers	[redacted]1977

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:

As part of the review activities for this report, the Department reviewed the county family files. Interviews with the caseworker and supervisor were held.

Children and Youth Involvement prior to Incident:

ACOCYF had one [redacted] report on this family prior to this incident. The report was received approximately three years before this incident and involved one of the half-brothers and his biological father. It did not involve the victim child or her parents, nor did it occur in this household. The agency completed an assessment on that father and determined no further interventions or services were necessary.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 10/21/2016, ACOCYF received two separate reports regarding the victim child's death, [redacted] Both reports essentially stated that the victim child's mother had fed the child in the early morning hours on that day and then placed the victim child in bed with the child's father, who was asleep. When the mother woke up at approximately 7:15 AM and went into the bedroom,

she discovered that the victim child was not breathing. Upon learning of the victim child's condition, the parents immediately called Emergency Medical Services (EMS) and the victim child was transported to CHP. EMS and the hospital personnel were unable to revive the victim child and she was pronounced dead.

Later in the day on 10/21/2016, ACOCYF dispatched an on-call caseworker to the home to assess the safety of the two half-brothers and speak with the parents. Upon arrival, it was learned that the two half-brothers were with their biological father. The caseworker interviewed both parents of the victim child about the incident.

The mother was interviewed first and provided information regarding her daily activities with the children, such as taking the two half-brothers to school and coming home and taking a nap afterwards. The home has a pack and play in the living room and a crib in the bedroom for the victim child. She also said that the victim child didn't really have a set schedule, as they fed her whenever she cried or they thought she was hungry. The victim child's father works 2:00 PM to 10:00 PM daily, but worked 12:00 PM to 10:00 PM the day before the incident.

On the evening 10/20/2016, the mother ran errands with the maternal grandmother and the victim child, then picked up her sons from their father's residence and took them through the drive-thru for dinner, which they ate at home. The mother fed the victim child a small amount and then placed her in the pack and play while she spent time with her sons until they went to bed at approximately 9:00 PM. She then watched TV until the father arrived home from work at approximately 10:20 PM. When the father got home, he picked up the victim child from the pack and play and played with her for a while. The parents fed the victim child at approximately 11:30 PM and then changed her, as she had a bowel movement. The mother reported that she fell asleep on the couch at approximately 1:00 AM and heard the victim child crying two times that night at around 2:30 AM and 4:30 AM. After the 2:30 AM feeding, she put the victim child back in the pack and play, but at the 4:30 AM feeding, she brought the victim child to the father, who was in their bed, and had him feed her, as the middle of the night feedings were his duties as per their agreement. The father began feeding the victim child and the mother went back to sleep on the couch.

When the mother awoke at around 7:30 AM, she went to check on the victim child with the father and found the father and victim child both in the bed, however, the victim child wasn't breathing. She reported that she woke the father and he immediately began cardiopulmonary resuscitation (CPR) and she called 911. The fire department and paramedics responded first, followed by the police. Because the half-brothers were in the home, the father remained home with them while the mother went to the hospital with the victim child.

The father's account from when he got home on 10/20/2016 was very similar to the mother's. He reported that he went to his bedroom at approximately 3:00 AM and played games on his phone for a while. He remembers the mother bringing the victim child into him between 4:00 AM and 5:30 AM. He said that he had a pillow next to the victim child to keep her from rolling off of the edge of the bed, but he also had the victim child propped up on a pillow by having her torso on the pillow but her buttocks at the bottom edge of the pillow. The father said that he was

woken up when the mother yelled that the victim child wasn't breathing. He initially thought she was just resting and tried to check and see if she was just sleeping. However, the mother was insistent that she wasn't breathing so the father began CPR and the mother called 911. The mother went to the hospital and he stayed at the home with the half-brothers and spoke to the police.

On the evening of 10/21/2016, the ACOCYF on-call caseworker went to the home of the half-brothers father to ensure their safety and assess their father's living environment. There were no concerns at this residence. A safety assessment was completed on the half-brothers and they were both deemed safe.

Also on 10/21/2016, the medical examiner's office performed an autopsy on the victim child.

The assigned ACOCYF intake caseworker visited the family home on 11/01/2016 and met with the victim child's parents to further interview them regarding the incident. The parents' accounts of the incident were consistent with their versions the first time they spoke with a caseworker.

During the week of 11/15/2016, the investigating caseworker spoke to the medical examiner's office, who informed the caseworker that the autopsy showed no signs of abuse. The caseworker also contacted CHP and spoke with a physician from the Child Advocacy Center, [redacted] They believed that the child's death was likely a result of unsafe sleep practices. The assigned caseworker also contacted the victim child's pediatrician, who also had no concerns. Lastly, the caseworker spoke with the investigating detective who advised that no charges were being pursued at that time, however, the District Attorney's office still needed to review the case. As a result of the information learned from these contacts, ACOCYF [redacted] the report and submitted their determination on 11/18/2016 as [redacted]

After completing their assessment, the agency determined that no further services were required for the family and ended their involvement with the family on 12/29/2016. Community resources were offered [redacted]

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:
Since Allegheny County OCYF submitted their report as [redacted] within 30 days from the report date, no review was necessary and an internal report was not completed.

- Strengths in compliance with statutes, regulations and services to children and families;

- Deficiencies in compliance with statutes, regulations and services to children and families;

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

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

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

Department Review of County Internal Report:
As stated in the previous section, no internal report was necessary, nor completed.

Department of Human Services Findings:

- County Strengths:
  - ACOCYF responded immediately to the home to assess the situation and the safety of the other children in the home. This included a late-night home visit to the half-brother's father's residence to ensure that was a safe environment for those two children.

  - ACOCYF made collateral contacts during their involvement with the family. They communicated with the investigating police officer, medical examiner's office, and the medical professionals to help gather information to help them make a decision regarding the outcome.

  - ACOCYF held an internal, preliminary meeting to review the incident. These meetings are standard protocol for the county and are beneficial for all involved. The Department is invited to participate in these meetings.

  - ACOCYF submitted their determination to ChildLine in a timely fashion (within 30 days).

- County Weaknesses:
  - The file provided only has one supervisory review documented from 10/21/2016 through 11/28/2016. These are to occur at least once every 10 days and be documented accordingly.

  - According to the case notes provided, the last contact was made on 11/18/2016. This contact was with the investigating detective, who advised the caseworker that the district attorney had not yet reviewed the case and it was unclear if charges would be filed. No other contact is documented after this date that clearly states the outcome of the criminal investigation.

  - According to the records provided by ACOCYF, the agency did not complete their [redacted] assessment of the family within 60 days. The report was received on 10/21/2016, making the 60th day 12/20/2016. However, the family wasn't closed until 12/29/2016.

- Although a safety assessment was completed on 10/22/2016 during the [redacted] assessment of the family, another one was never completed. Had the family's case been officially closed within 30 days of this assessment, a second one wouldn't have been required. However, the family wasn't closed with the agency until 12/29/2016, which required a second safety assessment be completed. This second safety assessment would have required another face-to-face contact with the children. Neither occurred.

- The complete file was not provided to the Department within 5 business days as required by the CPSL.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. After a review of the complete record, the Department found the following areas of noncompliance. They will be addressed in a Licensing Inspection Summary.

  - 3130.21 (b): Safety Assessment and Management Process
  - 3490.232 (e): Assessment not completed within 60 days

Department of Human Services Recommendations:

DHS identifies that there is a need for more public awareness regarding safe-sleeping practices of infants. This awareness could occur through public service announcements, billboard advertisements, resource pamphlets and/or other ways of notifying the public of the dangers of co-sleeping with an infant.