pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Trace Massie

Date of Birth: 04/10/2015
Date of Incident: 10/17/2016
Date of Report to ChildLine: 10/18/2016
CWIS Referral ID: [redacted]

FAMILY WAS NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Allegheny County 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 Children Youth and Families (ACCYF) did not have to convene a review team related to this report due to the fact that this case [redacted] within 30 days of the oral report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Trace Massie	Victim Child	04/10/2015
[redacted]	Mother	[redacted]1988
	Father	1987
	Brother	2011
	Sister	2008
	Sister	2010

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children Youth and Families (WRO) obtained and reviewed the records given by ACOCYF on this case. The Western Regional office also spoke to the investigating detectives and the coroner.

Children and Youth Involvement prior to Incident:

ACCYF had no prior involvement with this family.

Circumstances of Child Fatality and Related Case Activity:

On 10/18/2016, ACCYF received a referral surrounding the death of the victim child on 10/17/2016 at Children's Hospital of Pittsburgh (CHP). On 10/17/2016 the victim child was transported to CHP by local ambulance from the family home in full cardiac arrest. Upon arrival at CHP, life-saving efforts were attempted but the victim child died. There were no obvious signs of trauma [redacted] On 10/18/2016, the victim child's mother called [redacted] and expressed that she felt the father of the victim child had accidentally given him the older sibling's [redacted] At this point [redacted] called

the report into ChildLine and it was registered as a [redacted] report and a fatality.

ACCYF went out to the home on the night of 10/18/2016 and spoke to the victim child's mother. She advised that earlier in the day she had put the victim child down for a nap and when she attempted to wake him she was unable to arouse the child. Medics were called and they attempted cardiopulmonary resuscitation (CPR) both at the home and on the way to CHP, but the victim child was declared deceased in the Emergency Department. After the mother and the father returned home they began to talk and they expressed that the father may have accidentally given the [redacted] for the victim child's older sister to the victim child by accident. The older child did not like the taste of the medicine, so they mixed the medicine with a box of juice that they put into an empty tea bottle. The father gave both the victim child and the older brother a sandwich and some juice for lunch, inadvertently giving the victim child the medicine and then put him down for a nap because the child appeared sleepy after eating only part of his lunch and was beginning to sweat. The mother thought he was hot, put on a fan, gave him his juice to drink and he fell asleep on the couch. Approximately, 35 minutes later the father went to wake him up and could not rouse him. The mother ran in, slapped the victim child's face, tried to open his eyelids and there was no response. The father called 911 but was so distraught he could not speak so the maternal grandmother's paramour spoke to 911 and did CPR until medics arrived. Local police arrived at the home first, and took over CPR until the medics arrived.

The mother reported that the older sister [redacted] on 10/17/2016 and [redacted] The mother advises that she called the [redacted] Doctor on the night of 10/17/2016 to report what they thought happened and because it was after hours no one answered. The morning of 10/18/2016 she called [redacted] to report what they felt happened to the victim child. The father was never interviewed by ACCYF and it does not appear that they were able to obtain documentation from the detective on his interview with the father.

[redacted] Police detectives were also involved with the case and the detective assigned interviewed both the father and the mother. To date charges have not been filed, as they were still awaiting the results from the coroner on the cause of death and toxicology report. On 02/27/2017, the coroner received the toxicology and has ruled the victim child's death an overdose. The district attorney for Allegheny County is reviewing the case for possible charges. ACCYF [redacted] their case on 11/16/2016 citing that the victim child's death was accidental and the father accidentally gave the victim child [redacted] and the case did not meet [redacted] criteria. The case was subsequently closed and there has been no further contact with the family.

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

No County report was done due to case being [redacted] within 30 days

- Strengths in compliance with statutes, regulations and services to children and families;
  Not Required

- Deficiencies in compliance with statutes, regulations and services to children and families;
  Not Required

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  Not Required

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;
  Not Required

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  Not Required

Department Review of County Internal Report:
No County report was done due to case being [redacted] within 30 days.

Department of Human Services Findings:

- County Strengths: ACCYF immediately made contact with the family and ensured the safety of the other children in the home. They called all medical professionals involved and gathered information from collateral contacts within the family.

- County Weaknesses: No documentation could be found that the County interviewed the Father in this case. In the beginning, they were waiting on the Detective's to begin their case before they interviewed him, but there are no further notes about whether an interview with the father occurred.

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

  None

Department of Human Services Recommendations:

The Department would recommend that more knowledge be shared with parents about safe medication management [redacted] Particularly, if a medication can be mixed with a liquid to be administered and if so, how to safely do so that the dosage is not affected.