pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY:

Kyleigh McConnell

Date of Birth: 05/29/1999
Date of Death or Date of Incident: 01/10/2016
Date of Report to ChildLine: 01/14/2016
CWIS Referral ID: [redacted]

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

Beaver County Children and Youth Services
Westmoreland County Children's Bureau

REPORT FINALIZED ON:
09/09/2016

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.

Westmoreland County was not required to convene a review team in accordance with the Child Protective Services Law related to this report since the report [redacted] within 30 days of the date of the oral report from ChildLine.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Kyleigh McConnell	Victim Child	05/29/1999
[redacted]	Biological Mother	[redacted] 1968
	Biological Father	1965
	Sibling Brother	1996
* [redacted]	[redacted]	1991
*		1992
*		1993

*Denotes non-household members.

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families (WRO) obtained and reviewed all case records pertaining to the family including the files from Beaver County Children and Youth Services (BCCYS), Westmoreland County Children's Bureau (WCCB), [redacted] Police Department as well as the Bureau of Human Service Licensing (BHSL)'s report.

An Act 33 Fatality Review Team meeting was not convened because WCCB [redacted] the report within 30 days of the date of oral report from ChildLine. The agency did however provide WRO with a copy of the family case file which contained their investigative materials.

Children and Youth Involvement prior to Incident:

Beaver County Children and Youth Services (BCCYS) had two prior reports on the victim child. The first report was on 02/25/2015 with an allegation that biological father was verbally abusive on a regular basis to the point of causing the victim child emotional distress which led to her self-injurious behavior. At this time, it was noted that the victim child [redacted]

The BCCYS caseworker met with [redacted] who reported that he was aware of the allegations [redacted] reported that the parents do not work and the mother stays home all day. The father was unable to hold a job [redacted]

The BCCYS caseworker met with victim child at school [redacted] The BCCYS caseworker explained the investigation process to the victim child [redacted] In the meantime, the mother would ensure safety in the home. The victim child also reported to the caseworker that there have always been issues in the home with the father and when she was 3-years-old, her father had beaten her. The mother had contacted the police and filed charges as well as filed for a Protection from Abuse (PFA) order but later dropped them. The victim child reported the father [redacted] which led to him being verbally abusive.

According to caseworker contact on 02/26/2015, the mother confirmed to the caseworker that the father had left the home and was living with her father and brother in [redacted], Pennsylvania. The caseworker met with the father and he indicated that he attended a Primary Care Physician (PCP) appointment [redacted]

The second report was on 09/03/2015 which stated within the last three weeks, the victim child had attempted to overdose twice since the father returned home. The victim child was fearful of her father and the father has made statements to the victim child saying "I'm so mad I could hurt you." It was reported that during one of the victim child's overdose attempts, the father stated "you should have taken

more (medication)." It was also reported that the victim child's mother is downplaying the father's behavior towards their daughter.

The BCCYS investigation found the victim child had two overdose attempts and [redacted] The victim child was afraid of her father. The victim child reported she believed her father [redacted] and feared that he was going to get worse. [redacted] When the victim child was asked if she felt safe in the home, she replied feeling "ok" to stay in the home until she could attend camp [redacted] The mother reported the victim child was staying at a friend's house that evening [redacted]

[redacted]

The father reported to the BCCYS caseworker to having a history of anger control issues, [redacted]

The victim child was seen at the University of Pittsburgh's Medical Center (UPMC) Presbyterian Hospital on Tuesday 09/15/2015 for medical treatment for a cut on her wrist. Follow-up medical care occurred at UPMC [redacted] The worker indicated to the family the status determination of the investigation would be [redacted] and the case was then closed.

After BCCYS involvement ended, the victim child [redacted] she disclosed her plan to overdose on on 01/02/2016. She had been stock piling and stealing this [redacted] It was noted that on a scale of 0–100 and 100 being the most

lethal, the victim child rated her desire to die as "94" at that time. She also reported to burning her arms with a curling iron to distract from her emotional pain.

[redacted]

[redacted]

[redacted]

[redacted] She stated [redacted] she had a Suicide Ideation as recently as 01/04/2016 with a plan. She attempted to strangle herself [redacted] also admitted to burning herself and cutting herself when she is home. [redacted] The victim child also reported increased suicide ideation and self-injurious behaviors, increased isolation behaviors, decreased sleep, and feelings of hopelessness [redacted] The victim child was not able to identify any triggers.

In addition, the victim child reported she was sexually abused by a neighbor who was a year older then her when she was 8 or 11-years-of-age. She reported this occurred in the family's previous neighborhood where the family lived in [redacted] The mother reported that the alleged perpetrator has since moved to New York. A ChildLine report was made [redacted] when this was disclosed, but the family is still waiting for follow-up. WRO confirmed that this report was made on 11/20/2015. A Law Enforcement Referral was sent to Beaver County since the alleged perpetrator did not meet the Child Protective Services Law (CPSL) definition for a perpetrator. Other information reported [redacted] was that the victim child had only been in school 10 to 15 days this past school year due to [redacted] The victim child denied all drug and alcohol use. [redacted]

[redacted] it was identified the victim child had suicidal thoughts in the past few months, including a specific plan to commit suicide, and a history of suicidal attempts. [redacted]

[redacted]

[redacted] she had met [redacted] to talk about an issue of clothing that might have been a safety risk to her. The victim child expressed [redacted] she had thoughts about using the pillow case to harm herself. [redacted]

[redacted] she stated that her "goal for the next three years is to be dead" and "why do other people get to decide if I live or die." [redacted]

The following day the mother [redacted] expressed her concerns for her daughter's statements [redacted]

[redacted] a one day home pass for 01/09/2016. The victim child's mother picked her up [redacted] at 9:00 AM. The mother was provided with the victim child's [redacted] The victim child prepared a crisis safety plan which was reviewed with the mother and the victim child. The mother brought the child back [redacted] at 9:00 PM. Both the mother and the victim child reported the visit went well.

[redacted] She ate a small portion of her breakfast and was observed to have a positive attitude and reported her goal today was "no self-injurious behavior." She reported this was meaningful because "I need to stop because it's hurting other people". [redacted] The victim child reported to have shared that the worst day of her life was when "she failed to commit suicide". She also shared that one thing she wished she could do all over again was making the choice to not kill herself.

[redacted]

[redacted]

Approximately 10 to 15 minutes after the victim child entered the shower, [redacted] and stated the victim child made a comment to him that "tonight might be the last night you see me." [redacted] immediately started pounding on the shower door. When [redacted] heard no response, [redacted] called [redacted] over and they opened the door together. The victim child "was found unconscious hanging by a string on the shower rod". [redacted] immediately removed the victim child from the shower rod and began cardiopulmonary resuscitation (CPR). As the one [redacted] was engaged in CPR another [redacted] called the ambulance. Police and paramedics arrived and the paramedics took over [redacted] and began CPR measures. The victim child was transported to Allegheny Valley Hospital by ambulance. The victim child's parents were notified.

The Bureau of Human Services Licensing (BHSL) conducted an onsite investigation on 01/12/2016 and 01/13/2016 at [redacted] On 1/14/2016, [redacted] made a [redacted] referral to ChildLine alleging [redacted] failed to act. These identified individuals consisted of three staff [redacted]

BHSL made additional site visits in February and March of 2016 to complete their investigation into the incident and found multiple violations with the agency. The facility failed to develop a written plan to protect the victim child and the victim child's health and a safety assessment dated 01/05/2016 indicated a history of self-injurious behavior, suicidal ideation and suicide attempts.

[redacted]

Westmoreland County Children's Bureau (WCCB) received the [redacted] referral on 01/14/2016. WCCB was assigned the investigation since they did not have a contract with the facility and it was not a conflict of interest for them to conduct the investigation.

On 01/15/2016, the WCCB caseworker made a site visit [redacted] and spoke to the two program supervisors who were not working at the time of the incident. These two supervisors told the caseworker the events of that night after the suicide took place.

The WCCB caseworker completed interviews on 01/21/2016 with all three alleged perpetrators by telephone separately and advised them of their rights and to inform

them they were being named as alleged perpetrators. The WCCB caseworker asked the alleged perpetrator #1 at what point was he made aware of the victim child's suicide risk. He indicated that they were made aware of this at the time of the victim child's arrival. He had observed [redacted] remove items from the victim child's room at one point. He also reported that on the day of the incident the victim child was in good spirits, extra helpful to staff and interacted well with peers. The WCCB caseworker asked him about the facility's shower protocol and how often children are checked on and he reported there was no protocol, but they check on the children every 10 to 15 minutes by knocking and waiting for a verbal response. The alleged perpetrator #2 corroborated the agency had an unwritten but known shower protocol of verbally checking on the youth. The third alleged perpetrator did not know of the unwritten policy until after the incident.

The alleged perpetrator #1 explained the incident as it occurred. On the night of the incident, the victim child asked to take a shower approximately at 7:50 PM. He let the victim child into the shower. About 15 minutes later another resident told him that the victim child had made a statement to him about not being seen again. He and another alleged perpetrator went to the bathroom door and knocked and there was no answer. They unlocked the door and saw the victim child hanging from the shower rod. He took the victim child down and started CPR. The other alleged perpetrator called 911. While the alleged perpetrator #3 called the on-call supervisor. [redacted] alleged perpetrator confirmed [redacted] alleged perpetrator's statements and claimed that she was scheduled to participate in the crisis intervention and CPR trainings the following day. She explained that she was requested to contact the on- call supervisor and ask them to come to the unit after the victim child was found. She commented that she was in shock and froze, but recollected that she assisted the other residents to their bedrooms.

The alleged perpetrator #3 reported the victim child went into the shower a little before 8:00 PM and then came back out to grab something and then went back into the shower. [redacted] The alleged perpetrator #2 came to her and told her to call a supervisor, which she did. She did not know what was wrong at that time she made this call. She then went out and the [redacted] alleged perpetrator told her that he thought the victim child was dead. She reported that she then texted the on-call supervisor to come to the unit.

On 01/22/2016, the WCCB caseworker meet with the county solicitor, supervisor and county casework manager to discuss the case and all were in agreement the case could be [redacted] related to the three alleged perpetrators due [redacted] providing the victim child with the belt. The WCCB caseworker placed a telephone call to ChildLine and discussed the referral in regards [redacted] providing the belt to the victim child, which was used in a suicide. The ChildLine supervisor indicated [redacted] but the supervisor would need to speak to the Office of Children, Youth and Families, Western Region on how they wanted to handle it. On 01/28/2016 the supervisor and caseworker spoke to the Western Region Director who said that she would speak to ChildLine about the

matter. The Western Region Director contacted ChildLine and a determination was made the report would not be [redacted]

WCCB filed the [redacted] Report on 01/28/2016 with a finding of [redacted] for all three alleged perpetrators. The narrative states that "the caseworker found no evidence that any action or inaction on the part of any alleged perpetrator led to the death of the child. [redacted]

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

Westmoreland County Children's Bureau (WCCB) was not required to submit a fatality report as the ChildLine report was [redacted] within 30 days.

Department Review of County Internal Report:

Westmoreland County Children's Bureau (WCCB) was not required to submit a fatality report as the ChildLine report was [redacted] within 30 days of the oral report.

Department of Human Services Findings:

- County Strengths:
    - The county completed a site visit within 24 hours of receiving the report [redacted] The county caseworker obtained the child file while she was at the facility.
    - The county caseworker spoke to the [redacted] Police Officer and got copy of the police report and findings. The county spoke to the Western Region Director, and Bureau of Human Services Licensing (BHSL).

County Weaknesses:

- WCCB's documentation of their intake investigation is minimal. The focus of their investigation was what happened after the victim child's suicide not the events that led up to the suicide. There was only mention of the victim child's mood during the day.
- The WCCB investigation did not include documentation that the caseworker walked through of the facility. The WCCB case file did not include documentation as to which bathroom the incident took place in and if the caseworker viewed that bathroom. There is no case documentation if the caseworker addressed where the green chair that the victim child used to commit suicide was kept at the facility. In

addition the case documentation does not address how the victim child was able to get the chair and put it in the shower.

- [redacted] There was no documentation that the daily schedule was reviewed. What the individual staff responsibilities and their locations in the facility at the time of the incident were not documented. What belongings residents were allowed to have at the facility was not addressed. There was no documentation as to how the facility searches a resident's belongings when they were returned from a home pass to determine how the victim child was able to bring the belt into the facility.
- WCCB interviewed the three alleged perpetrators individually by telephone. The case documentation is silent as to the reason for interviewing the alleged perpetrators by telephone.
- WCCB did not interview [redacted] who witnessed the incident. In particular [redacted] who alerted the staff to the victim child's plan and who was interviewed by the police. The case documentation does not address the reason as to why [redacted] were not interviewed. By interviewing the alleged perpetrators by telephone and not interviewing [redacted] in the facility WCCB was limited to only the alleged perpetrators version of the events.
- The 01/22/2016 WCCB case documentation states that [redacted] provided the child with the belt which was the reason for making the status determination of [redacted] WCCB did not interview [redacted] to confirm that [redacted] provided the victim child with the belt. There was no case documentation that they requested that BCCYS interview [redacted] and other family members. No other family members were interviewed as to events of the home visit on 01/09/2016 to determine if [redacted] gave the victim child the belt.

<u>Statutory and Regulatory Areas of Non-Compliance by the County Agency.</u>

- 3490.55 requires that when conducting its investigation the county agency shall if possible conduct an interview with those persons who or may reasonably be expected to have information related to the incident of suspected child abuse. WCCB failed to interview [redacted] and other family members to confirm that she provided the child with the belt which is related to regulation §3490.55(d)(2).

  The WCCB caseworker did not interview [redacted] who alerted the facility staff of the victim child telling him that she was not going to be seen again or [redacted] who witnessed the incident as related to state regulation §3490.55(d)(5).

- CPSL 6368(d)(4) requires that all subjects of the report be interviewed. If a subject of the report cannot be interviewed then the

county agency shall document its reasonable efforts to interview the subjects of the report and the reasons for its inability to interview the subject. The WCCB documentation did not include their reasonable efforts to interview [redacted] and [redacted] who witnessed the incident and the reasons for their inability to conduct those interviews. There was no documentation in the file that WCCB requested BCCYS interview [redacted] and other family members.

Department of Human Services Recommendations:

- It is recommended BHSL work with Chapter 3800 licensed agencies on what is classified as an acceptable written plan for self-injurious behaviors / suicide risk or work to develop a self-injurious behaviors / suicide risk policy and procedure for these agencies. The Department has noted that Bureau of Juvenile Justice Services (BJJS) has issued a Suicide and Self-Injurious Awareness and Management Policy and Procedure that BHSL could look at to adopt of utilize to develop own guidelines/policy and procedures.
- There were three program offices of the Department of Human Services that reviewed this incident. BHSL reviewed the facility, [redacted] reviewed the [redacted] component of the facility and Western Region OCYF reviewed the child fatality. The Department needs to develop a mechanism to facilitate communication between the program offices when multiple program offices are conducting investigation of the same incident.