REPORT ON THE FATALITY OF:

Orlando Coleman

Date of Birth: 09/30/2016
Date of Death: 11/27/2016
Date of Report to ChildLine: 03/03/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Fayette County Children and Youth Services

REPORT FINALIZED ON:
08/23/2017

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))

Office of Children, Youth, and Families, Western Regional Office
11 Stanwix Street Suite 260, Pittsburgh, PA 15222 | 412-565-5777 | Fax: 412-565-7808 | www.dhs.pa.gov

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.

Fayette County Children and Youth Services (FCCYS) has not convened a review team in accordance with the Child Protective Services Law related to this report. The County [redacted] the case on 03/29/2017, within 30 days of the date of report therefore not requiring review team meeting.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Orlando Coleman	Victim Child	09/30/2016
[redacted]	Mother	[redacted] 1993
* [redacted]	Father	unknown
[redacted]	Sibling	[redacted] 2013
[redacted]	Sibling	[redacted] 2011

* 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:

The Western Region Office of Children, Youth and Families (WERO) obtained and reviewed all records pertaining to the [redacted] family. The County [redacted] the allegations of causing the death of a child through an act of interfering with breathing on 03/29/2017.

Children and Youth Involvement prior to Incident:

On 10/16/2016, Fayette County Children and Youth Services (FCCYS) screened out a report, having no contact with the family. The report identified concerns that the mother missed a doctor's appointment, however there were no concerns reported for the health of the child.

Circumstances of Child Fatality and Related Case Activity:

FCCYS received four [redacted] reports on 03/03/2017 regarding the family. Two of the reports were alleging serious physical neglect due to a prolonged lack of supervision regarding the two surviving children of this report. The third report alleged [redacted] had caused bruising on the male sibling after "whooping" him. The fourth report involved the death of the victim child, which occurred on 11/27/2016. All of the reports named [redacted] as the alleged perpetrator and all of the reports were determined to be [redacted]

Specifically in relation to the victim child's report, [redacted] was registered for causing the death of the victim child through an act of interfering with breathing. At the time of the death, the autopsy report stated the child died as a result of SIDS. The reporting source on 03/03/2017 alleged that [redacted] was drunk and rolled over on the victim child causing the victim child to aspirate; dying as a result. There was no police involvement at the time of the victim child's death and no report was made to FCCYS. Upon receipt of the 03/03/2017 report, FCCYS contacted the Police and was informed there was not an active investigation into the incident due to the coroner's cause of death being SIDS. FCCYS conducted their investigation, which included a review of the medical records and coroner's report. There were no concerns identified pertaining to the victim child's death. It was determined there was not sufficient evidence to support the allegations and the report was determined to be [redacted]

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

- Strengths in compliance with statutes, regulations and services to children and families;
  none
- Deficiencies in compliance with statutes, regulations and services to children and families; none
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  none
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and none
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. none

Department Review of County Internal Report:

Fayette County completed the investigation within 30 days. The report was submitted as [redacted], therefore not requiring a county team meeting or report.

Department of Human Services Findings:

- County Strengths: The County conducted a timely and thorough investigation and made all necessary collateral contacts, including family members and law enforcement.
- County Weaknesses: No county weaknesses were identified.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were no statutory or regulatory areas of non-compliance.

Department of Human Services Recommendations:

The Department does not have any recommendations at this time.