REPORT ON THE FATALITY OF:

Jaclynn Heffner

Date of Birth: 12/12/2016
Date of Death: 04/21/2017
Date of Report to ChildLine: 04/20/2017
CWIS Referral ID: [redacted]

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

Westmoreland County Children's Bureau

REPORT FINALIZED ON:
09/01/2017

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))

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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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 05/17/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Jaclynn Heffner	Victim Child	12/12/2016
	Biological Mother	1985
	Biological Father	1984
	Sibling	2011
	Sibling	2014
	Sibling	2015

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children Youth and Family Services reviewed the case and casework activities to the current referral and previous referrals with the Westmoreland Children's Bureau Act 33 Review team. The Western Region obtained and reviewed documentation from Westmoreland County Children's Bureau and medical reports.

Children and Youth Involvement prior to Incident:

Westmoreland County Children's Bureau received three previous reports for the family.

All three of the family's referrals were initiated as a result of mother testing positive for marijuana while pregnant with three of her four children. The first referral is received on 12/21/2011, the second on 12/09/2014 and the third referral, which is the birth of the victim child, was received on 12/13/2016. The County assessed the family within the sixty days for each referral and determined the parents were appropriate. During face to face contacts the parents did not appear to be under the influence of any illegal substances. The second referral were aware and advised mother of the possible harmful effects of use

while pregnant. The third report indicated the mother used marijuana for nausea issues during pregnancy.

Circumstances of Child Fatality and Related Case Activity:

Westmoreland County Children's Bureau received a referral on 04/20/2017 regarding the fatality of a 4-month-old female. The report noted [redacted] had left the victim child in the care of [redacted] had laid the child down on her back on the parents' queen sized bed. [redacted] had placed pillows around the child but was not able to recall if he placed a pillow under the victim child's head. [redacted] left the bedroom and went to the living room to put a movie in for the other children to watch. Upon returning to the bedroom the victim child was lying on her stomach and her face was blue. [redacted] ran to the neighbor's residence for assistance and called [redacted] to return to the home stating "I did something bad." This phone call occurred approximately 15-20 minutes after [redacted] had left the home. The neighbor called 911. The victim child was transported to the local hospital in [redacted] PA. The victim child was initially examined [redacted] at the Hospital but then sent by air-ambulance to Children's Hospital of Pittsburgh where she was pronounced deceased. The coroner report did not show any signs of abuse or neglect. The cause of death was ruled as Sudden Infant Death Syndrome (SIDS). There were no previous health or medical concerns regarding the victim child. Reportedly, this was the first time the victim child had rolled onto her stomach while sleeping. During the investigation [redacted] later stated he called [redacted] and said he had done "something bad" and clarified he was berating himself.

[redacted] Police conducted an investigation and also determined the incident to be accidental therefore no charges were pressed. It was also reported [redacted] were shown a video regarding SIDS and safe sleep practice [redacted] after the birth of the victim child. Westmoreland County provided the family with a community service referral [redacted]

In regards to the allegations of causing the death of a child through a recent act, Westmoreland County Children's Bureau submitted an [redacted] investigation outcome on 05/30/2017. The determination was made 40 days after the date of referral.

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

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

  There were no summaries to review of County strengths, deficiencies and recommendations for change as identified by the County's Child Fatality Report due to the County not completing a report.

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

  There were no summaries to review of County deficiencies in compliance with statutes, regulations and services to children and families due to the County not completing a report.

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

  There were no summaries to review of County recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse due to the County not completing a report.

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

  There were no summaries or recommendations for changes at the state and local levels on monitoring and inspection of county agencies due to the County not completing a report.

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

  There were no recommendations to review of recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse due to the County not completing a report.

Department Review of County Internal Report:

Westmoreland County Children's Bureau did not complete a County Internal Report in relation to the meeting held on 05/17/2017.

Department of Human Services Findings:

- County Strengths:
  The County responded to the report in a timely manner and assured the safety of the other children in the family home.

  The County collaborated with law enforcement and medical professionals throughout the investigation.

  The County provided referrals to community services to the family.

- County Weaknesses:

In regards to the prior referrals for exposure to illegal substances at the birth of a child, the mother screened positive for marijuana; however there was no follow up regarding any impact of parenting by the mother other than subjectively noting the parents did not appear to be under the influence while conducting home visits. A secondary weakness to these assessments was the documentation that the father was only interviewed by telephone in the prior referrals. The County stated the parents appeared to not be under the influence is subjective and after multiple reports for the same concern completed little follow up.

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

  CPSL 6365 (d) (4) (v) A child fatality review team shall be convened by a county agency when the county agency has not made a status determination within 30 days. The team shall, within 90 days of convening, submit a final written report on the child fatality to the department and designated county officials under section 6340 (a) (11).

  - Westmoreland County Children's Bureau received the report of suspected child abuse related to the fatality of the child on 04/20/2017, at which a review team convened on 05/17/2017. The county failed to provide a written report to the Department within 90 days of the date of the review team meeting. Upon the writing of this report, the county had not submitted a final report.

Department of Human Services Recommendations:

The Department would continue to recommend hospitals continue to have parents view a safe sleep video prior to discharge and ensure this takes place by conducting follow up conversations/review of the material and having the parents sign an acknowledgement form the material was presented with the understanding of the inherent risks. It would also be recommended the information is not presented while the mother is under the effects of any form of narcotics or while the parents appear to be asleep. Hospital staff should be present while presenting the videos to the parents.

The Department would recommend county children and youth agencies, upon receiving a positive screen for illegal substances at the birth of a child, conduct urine screens and complete more formal assessments for ongoing concerns of drug/alcohol usage.