pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Chyra Howard

Date of Birth: 06/23/2014
Date of Death: 03/07/2017
Date of Report to ChildLine: 02/27/2017
CWIS Referral ID: [redacted]

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

Clearfield County Children and Youth Services

REPORT FINALIZED ON:
08/31/2017

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.

Clearfield 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 03/20/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Chyra Howard	Victim Child	06/23/2014
[redacted]	Mother*	[redacted] 1997
	Father*	1986
	Paternal Grandmother*	
	Maternal Grandmother*	
	Paternal Great Grandmother*	
	Maternal Aunt*	
	Foster Mother	[redacted] 1978
	Foster Father	1977
	Foster Sister	2003
	Foster Sister	2005
	Foster Sister	2012
	Foster Brother	2000

* 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 (WRO) reviewed the Clearfield County Children Youth Service (CCCYS) case records pertaining to the birth family. The Lifespan Family Services of Pennsylvania (Lifespan) foster agency files for the foster family and the victim child were also reviewed. CCCYS convened an Act 33 meeting on 03/20/2017 as the case was not [redacted] within the 30 days. The WRO attended this meeting. The WRO also reviewed all information pertaining to this case in the Child Welfare Information System database.
The victim child was in Children's Hospital of Pittsburgh (CHP) for eight days prior to her death. During that time, the WRO visited the hospital on 03/01/2017, 03/02/2017, 03/03/2017, and 03/06/2017. The WRO attended the forensic interview on the youngest foster sibling at CHP's Child Advocacy Center (CAC). The

WRO had telephone conversations with the [redacted] Police Department. The WRO interviewed [redacted] at CHP, case workers at CCCYS and foster care staff from Lifespan.

Children and Youth Involvement prior to Incident:

CCCYS had involvement with the mother as a child and as a parent. At the time of the incident, the mother had an open case with CCCYS. She also was on Juvenile Probation at the time of the incident. The father also has an open case with the agency with his wife and her children. There is a current Protection from Abuse Order (PFA) on him which was filed by his wife. The father was incarcerated in the [redacted] jail for violation of the PFA at the time of the incident.

CCCYS has had 44 referrals on the maternal grandmother and her children since 2009. The maternal grandmother has eight children. Three referrals were [redacted] referrals and 40 were [redacted] referrals. In addition there was 1 Juvenile Probation referral on the mother. The majority of [redacted] referrals were due to home conditions in the maternal grandmother's home and her drug use/abuse. At the time of the incident, six of the maternal grandmother's eight children were under the age of eighteen. The maternal grandmother also provided care for the victim child at different times [redacted]

CCCYS received a [redacted] referral on 01/06/2016 on the mother as a parent due to the mother using methamphetamines and not checking in with her juvenile probation officer. The mother and the victim child were residing in the home of the maternal grandmother along with the mother's six siblings who were under the age of eighteen. CCCYS assigned a three day response time to the referral. A caseworker visited the maternal grandmother's home on 01/08/2016. Upon arrival at the home, the mother was not there. The maternal grandmother stated that the mother was with her sister, maternal aunt, in [redacted] and was not to return home for about two weeks. Reportedly the mother was in and out of the maternal grandmother's home. [redacted]
CCCYS did not see the victim child during this home visit.

The next documented home visit was on 02/11/2016. According to the case file it did not appear that any attempts were made to see the victim child until the February announced home visit. Upon arrival at the home, the caseworker and maternal grandmother engaged in a conversation about the mother. During this home visit the caseworker heard the maternal grandmother admitting to her probation officer that she used crystal methamphetamine over the weekend. The maternal grandmother showed the caseworker the mother's room, which was in total disarray. In the room, there was broken glass on the floor, ashes on the windowsill and an entertainment center was on the floor broken in pieces. The maternal grandmother's paramour was drug tested and was positive for [redacted] and methamphetamines. The mother and father's whereabouts were unknown at the time of this visit. [redacted]

[redacted] The victim child was then placed in a foster home provided by LifeSpan.

[redacted] While the father was incarcerated the paternal grandmother who lived in New York state sought custody of the victim child. She started the Interstate Compact process but did not complete the required paperwork.

Foster Care Agency Involvement Prior to the Incident:

The foster parents applied to be foster parents in 2013 and were approved as foster parents in 2015. They have only been foster parents through LifeSpan. The foster mother had worked as a [redacted] and wanted to provide children with love, consistency and a family. The foster parents had talked about being foster parents for several years prior to applying. At the time that they applied to become foster parents their household consisted of the foster mother, foster father and their two biological daughters. The foster parents were able to successfully complete the components of the home study process. The agency received positive references on the foster parents. The foster family home is located in a middle class gated community. They were approved as a foster to adopt home and accepted both short and long term placements. The foster parents had four children placed with them prior to this incident. One of the children was recently adopted. Neither Lifespan nor County staff expressed concerns for any of the placements in the foster home. The CCCYS caseworker's dictation stated that the victim child was clean, happy and well-adjusted at each visit. Throughout the victim child's placement the foster family was willing to work with the biological family during visits. They would transport to and from visits and would discuss the behaviors the victim child displayed after the visit was completed. At the time of the incident, the foster family household consisted of the foster mother, foster father, their two biological daughters, one adopted daughter and one foster son, along with the victim child.

Circumstances of Child Fatality and Related Case Activity:

On 02/27/2017 a report [redacted] was received stating that the victim child was in CHP with multiple life-threatening injuries [redacted] The victim child sustained these injuries when a television set which was sitting on a dresser in her bedroom fell on her on 02/26/2017. The report was upgraded to a fatality on 03/07/2017.

On the morning of 02/26/2017 the foster family was preparing for a family fun day. The foster mother had various activities planned for all the children. Prior to embarking on the day's activities, the foster father went into the kitchen to make a quick lunch and the foster mother and children went upstairs to get ready. The oldest foster sister took the youngest foster sister and the victim child into their bedroom, and put a movie on and closed the door. They were to rest until lunch was ready and then after lunch the family was going to leave for the day. The oldest foster sister then left the bedroom and went to her bedroom to clean up and

get ready for the day. The foster mother went to her bathroom, which is adjacent to her bedroom which is only several feet away from the bedroom where the victim child was watching a movie. The other foster sister went into her room as well to get ready. The foster brother was in the main bathroom on the same floor getting ready. It should be noted that the door to the bedroom where the victim child was watching a movie can be seen from any other doorway in the upstairs. The hallway is rounded not a long hallway. Each doorway exits into the same area.

After a few moments of everyone getting ready, a loud bang was heard from the victim child's bedroom. The foster father initially stopped what he was doing but did not hear an immediate cry and continued to make lunch. The other children and foster mother ran to the bedroom and the door was locked. After a few seconds the youngest foster sister opened the door and began to scream "she's dead." The foster mother immediately screamed and the foster father was upstairs within seconds. The victim child was lying on the floor with a large dresser on top of her. A large, older television with a picture tube was also on the floor. The foster father grabbed the dresser and pushed it off of the victim child. The second oldest foster sister grabbed the youngest foster sister and took her out of the room. The oldest foster sister grabbed the phone and called 911 and handed the phone to the foster mother.

The victim child had blood coming out of her ears and nose. She was breathing, but gasping for air. The foster father rolled the victim child on her side as instructed and the victim child immediately vomited blood. The foster siblings went downstairs and outside to watch for the ambulance. Both foster parents remained with the victim child. The foster mother remained on the phone with 911 until the ambulance arrived. From the 911 call, the local police department was alerted and arrived on scene. It is believed that it took approximately 19 minutes for the ambulance to arrive due to the location of the foster family home. The oldest foster sister called her grandparents and the staff from Lifespan while waiting for the ambulance. [redacted] alerted CCCYS to the incident.

Upon the arrival of the medical personnel to the foster home they immediately called a medical helicopter due to the trauma of the victim child. The victim child was breathing but she was not responsive. The medical personnel worked on the victim child for a few minutes in the ambulance and then left to meet the helicopter a few minutes down the road. [redacted] The foster mother stayed with the victim child the entire time. She rode in the ambulance with her and then on the helicopter to CHP. The youngest foster sister remained with her grandparents. The foster father with the other three foster siblings drove to CHP to be with the victim child and the foster mother. Prior to leaving for Pittsburgh, the [redacted] Police department interviewed the foster father for a basic facts interview.

The case manager from Lifespan had arrived at the foster home as the ambulance was meeting the helicopter. She also drove to CHP to be with the family. The

biological mother and biological father were both notified by telephone by the caseworker from CCCYS.

Upon arrival at CHP the victim child was immediately assessed [redacted] The biological mother needed to be called as medical permission was needed from her for medical procedures. She was not immediately available. The CCCYS caseworker found her by phone and relayed the call to the physician by three way call to allow the physician to speak with her. The physician explained what was needed to be done and the biological mother did agree to the procedure. [redacted] it was unclear of the damage that was done or the long term prognosis. [redacted]

Over the next several days, the victim child's condition did not improve. [redacted] There were times that the victim child did respond to voices and touch. Some of the family members were arguing [redacted] and the medical personnel needed to intervene and remove [redacted]

A visitation schedule was put into place to allow each family to have alone time with the victim child. This was to decrease the amount of arguing that was done around the victim child. Due to the child being monitored in the hospital, supervised visits with the biological family were not warranted. The biological family was able to visit with the victim child three times per day. The biological family included the mother, paternal and maternal grandmother, paternal great grandmother, and maternal aunts and uncles. The foster family was not to be present at those visit times. The foster family remained with the victim child whenever the biological family was not visiting. The foster father and foster siblings stayed at the Ronald McDonald house to remain close. The foster family had numerous family members visit as the victim child was an integral part of the foster family. The foster mother rarely left the victim child's side unless it was a scheduled biological family visit. The biological family was given specific instructions that the victim child was not to be alone. The foster family was to be called if they needed to leave the visit early.

Initially, the biological family visited for long durations, but as the victim child's condition did not improve the biological family would stand by the bed side for a few moments and then leave the room. The foster family was alerted when the

biological family left early. [redacted] Numerous conversations were held [redacted] with the biological family. The paternal grandmother arranged with the [redacted] courts and sheriff department for the biological father to come and visit the child. [redacted]. On 03/07/2017 after numerous conversations with the treating physicians, the biological mother and father made the decision to remove the victim child from life support and donate her organs. The victim child was declared legally deceased on 03/07/2017. The victim child was not completely removed from life support until 03/09/2017 due to the biological family wanting to donate the organs. The foster parents remained with the victim child until 03/09/2017 until the victim child was taken by Center for Organ Recovery and Education (CORE) to have her organs donated.

While the foster family was in the hospital, workers from Lifespan went to the foster family home and bolted all dressers and cabinets to the walls. They established an internal policy that all foster homes will have dressers and cabinets bolted to walls. The case managers from Lifespan spent many hours at CHP supporting the foster family during this incident.

WRO was assigned the [redacted] investigation due to the conflict that CCCYS has a contract with Lifespan. The WRO submitted the [redacted] report with a status of [redacted] on 04/07/17. The [redacted] Police Department felt this was a tragic accident. They closed their case and did not file charges.

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;
    - Staff from Clearfield County Children Youth, Department of Human Services, [redacted] Police Department, LifeSpan Family Services, and Children's Hospital of Pittsburgh continuingly had an open line of communication and would frequently discuss concerns as they were occurring.

- 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;
    - Lifespan Family Services has established new guidelines for their foster home in regards to securing dressers and what is allowed to be on dressers.
    - Lifespan Family Services has [redacted] services for the foster family.
    - [redacted] Department of Human Services made a suggestion that the Clearfield County Children, Youth, and Family Services should have been at Children's Hospital of Pittsburgh sooner.
    - Clearfield County Children, Youth, and Family Services will discuss with foster parents about putting toys and items of interest (TV's, game systems, books) on dresses or high shelves. The Agency will also discuss guidelines on securing dressers.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
    - None identified

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
    - None identified

Department Review of County Internal Report:
WRO reviewed CCCYS report that was submitted. The report was brief and did not offer an analysis of the circumstances surrounding the incident and how the agency responded to the incident.

Department of Human Services Findings:

- County Strengths:
    - County agency worked in concert with the local law enforcement.

- County Weaknesses:
    - When WRO reviewed the family's case file the dictation did not include the discussion of the death of the child.
    - CCCYS's report did not provide a clear picture of what happened during the incident.
    - The victim child was hospitalized at CHP on 02/26/2107 but CCCYS staff did not come to the hospital until 03/02/2017 and only after WRO intervened. When WRO staff went to the hospital on 03/01/2017, the conflict between the birth and foster families visiting victim child was identified. CCYS should have immediately visited the hospital to set

the parameters for visitation for the birth and foster families with the victim child.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None identified

Department of Human Services Recommendations:

The Department agrees with CCCYS's recommendation that providing education to foster parents regarding the importance of not putting toys and items of interest to children, such as TV's, game systems and books, on high dressers or shelves due to safety concerns. The Department also agrees with the recommendation that foster care agencies establish Guidelines or policies regarding securing dressers/cabinets to walls.

The Department also recommends that a training be made available for county children and youth service agencies, as well as appropriate Department staff regarding the requirements for Child Fatality and Near Fatality reports.