pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Julian Hoffman

Date of Birth: 01/16/2011
Date of Death: 08/09/2017
Date of Report to ChildLine: 08/09/2017
CWIS Referral ID: [redacted]

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

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:
01/12/2018

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 has convened a review team in accordance with the Child Protective Services Law related to this report. The county preliminary review team meeting was held on 09/06/2017 with the larger team being convened on 09/25/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Julian Hoffman	Victim Child	01/16/2011
	Mother	/1987
	Father(deceased)	/1986
	Sibling	/2007
	Mother's paramour	/1970
	Paramour's daughter	/2009
	Paternal Aunt	/1967

* 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 Family Services reviewed the case and casework activities to the current referral and previous referrals with the Caseworker and Allegheny County Act 33 Review team.

Children and Youth Involvement prior to Incident:

Allegheny County Office of Children, Youth and Families (ACOCYF) received four previous referrals for the family.

Three referrals were received in 2015. The first referral was in July 2015. It was a referral with The allegations addressed included the mother's alleged use of illegal substances and leaving the

child home unsupervised. This referral was assigned as a [redacted] [redacted], which was completed and [redacted]

The second referral was a [redacted] It was an [redacted] report however was noted and referred to in history of the prior referrals provided by ACOCYF. Specific details regarding the referral were not made available.

The third report was received in October 2015 as a [redacted] referral noting allegations of inadequate housing and inadequate hygiene. The victim child was reported to not have on socks or undergarments at school and described as having dirty feet and fingernails. This report was [redacted] as ACOCYF was involved with the family and actively investigating the referral from September.

In March 2017, ACOCYF received a fourth referral. The report was a [redacted] referral [redacted] The victim child was injured at school during gym class. Upon the school's ongoing observation of the victim child's behaviors the decision of immediate need for medical attention became apparent. The mother's lack of response to the noted injury was concerning, however upon investigation the mother took appropriate action. During this investigation, the ACOCYF was informed the older brother was caring for the younger sibling (five years old) for approximately one hour after school. The ACOCYF completed collateral contacts with the sibling's [redacted] who noted the child was "extremely mature, insightful, open and honest". The conclusion from the collateral contact was the sibling was believed to be able to supervise his younger brother during the approximate one hour alone at home. The investigation was closed without accepting for services; the report was [redacted]

Circumstances of Child Fatality and Related Case Activity:

On 08/09/2017, ACOCYF received a [redacted] report [redacted] regarding the fatality of a 6-year-old male child. The victim child and [redacted], had been left unsupervised at the mother's residence. [redacted] contacted his mother at work and told her he had shot the victim child with her firearm. [redacted] then contacted emergency services who arrived at the family residence and immediately transported the victim child to Children's Hospital of Pittsburgh, where he was pronounced deceased.

ACOCYF attempted to complete a home visit on 08/09/2017 with the mother but was only able to speak with her paramour by telephone. ACOCYF was informed the sibling was with a paternal cousin.

Through the investigation it was found that [redacted] had left for work on the morning of the incident leaving the children, her paramour and his daughter at home asleep. [redacted] stated she had left the firearm in a bag, which she thought she had left in the trunk of her car. She received a telephone call from [redacted] while she was at work informing her of the incident. The

paramour stated he had left the home that morning for work with his daughter. He stated to ACOCYF he observed the victim child to be asleep in his bed and did not want to awake him then left for work. The paramour later provided a statement he and the older sibling had unloaded car the night before and brought the mother's purse into the home, placing it on a dresser, unaware the firearm was in the purse.

initially disclosed to law enforcement the victim child had located the firearm and shot himself. later reported to law enforcement as well as during a forensic interview he had taken the clip out of the firearm, thinking that it was unloaded and not realizing there was a bullet in the chamber, told the victim child to stick his hands up and then pulled the trigger. The victim child was shot to the face and passed away as a result of the injuries.

During collateral interviews obtained by law enforcement and conducted by ACOCYF, it was found that the mother would leave the children home unsupervised between sixteen to twenty hours a day. disclosed that he was present when she purchased the firearm for protection. He had seen it at home in an unlocked box in the closet. He disclosed witnessing the mother engage in illegal substance use. As a result of disclosure of physical maltreatment a referral was completed.

ACOCYF did not accept the family for services as the surviving child was placed with his paternal aunt who actively engaged in obtaining The paternal aunt petitioned the court on 08/17/2017 for temporary guardianship and was later granted permanent guardianship on 09/27/2017. ACOCYF also referred support services to the paternal aunt and surviving child.

A referral was assigned regarding the paramour and his daughter. This referral was not accepted for ongoing services after completing an initial assessment.

was charged with four counts of Endangering the Welfare of Children (two felony and two misdemeanor), two felony counts of Materially False Written Statements of the purchase, delivery, and transfer of firearm, one misdemeanor count of the Use/Possession of Drug Paraphernalia and one misdemeanor count of Possession of Marijuana. As of 10/01/2017, the ChildLine investigation was submitted as due to these charges.

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;
    - The on-call caseworker responded immediately to the family's home and followed up via telephone when the family was determined to not be home.
    - The [redacted] caseworker responded immediately to the paternal kin's home to assure the surviving brother's safety.
    - The [redacted] caseworker conducted interviews with all relevant family members and with collateral contacts (i.e., [redacted] [redacted], educational and physical health providers).
    - The [redacted] supervisor and caseworker remained in contact with law enforcement to ensure a joint investigation.
    - CYF completed a referral for community supports to assist the paternal aunt in caring for the surviving child.
    - A [redacted] referral was completed for the intimate partner's daughter, who had been visiting with the family at the time of fatality.
    - Following the fatality, CYF referred the paternal aunt and surviving brother to [redacted] for support and linkage with additional community supports.

- Deficiencies in compliance with statutes, regulations and services to children and families;
    - Documentation was minimal for the 2015 GPS referrals and did not indicate a comprehensive assessment.
    - The Review Team noted that the initial safety assessment was conducted outside of the regulatory time frame. Subsequent safety assessments that were completed identified the mother as the caregiver, [redacted] the brother in the paternal aunt's care.

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

- The Review Team discussed the CYF practice guidelines for assessing levels of supervision, specifically determining when children can be safely left home unsupervised and can safely supervise other children, with no adult supervision.
    - CYF encourages caseworkers to provide families with a brochure, entitled, *Home Alone-Is Your Child Ready*, when considering leaving their child(ren) at home without adult supervision.
    - The Review Team further discussed that age should be one of several factors for consideration and that families should be encouraged to consult with their pediatrician, service providers, and mature and thoughtful natural supports when making this decision.
    - The Review Team discussed various childcare options that are available and the possibility of leveraging school districts as partners for identification of childcare during summer months (when school is no longer in session.)
- The Review Team recommended that caseworkers adhere to the Investigative Practice Standards to ensure that collateral contacts are completed in all referrals. This will allow caseworkers to gain insight into other facets of a family's life and obtain a clear understanding of strengths and needs.
    - In the most recent referral, collateral contacts were completed for the children's education and medical providers, and with the brother's [redacted] provider.
    - In previous referrals, documentation did not reflect that collateral contacts were completed.
- The Review Team noted that the initial safety assessment was conducted outside of the regulatory time frame. Subsequent safety assessments that were completed identified Mother as the caregiver, [redacted] the brother in the paternal aunt's care.
    - The Review Team recommended that CYF staff adhere to practice standards by completing the Safety Assessment in a timely manner and ensuring that all household members and caregivers are thoroughly assessed for safety and risk.

- The Review Team discussed that the Pa DHS OCYF Risk Assessment protocol requires that, "Chemical substances or dangerous objects such as guns improperly stored and within reach of children," be assessed as risk factors in a family home. Allegheny County CYF does not require nor has trained casework staff to assess guns as a risk factor.
    - The Review Team recommended that CYF leadership review its procedures for risk assessments, including the barriers to and solutions for casework staff to safely and effectively include gun safety, including safe storage.
    - The Review Team further discussed the viability of supplying firearm locks, or resources to obtain these locks, to families when caregivers note that their weapons are not secured.
    - The Review Team reviewed current gun prevention strategies that the county employs.
- The Review Team discussed the availability and adequacy of [redacted] The team stressed the importance of obtaining collateral information from other sources, such as school or pediatrician, to ensure [redacted]
- The Review Team reviewed the county's Community of Practice for [redacted] providers serving families involved with CYF. The Community of Practice is designed to improve the delivery of [redacted] services to child welfare-involved families. DHS defines a Community of Practice as a group of specialized providers that share a concern, capacity and passion about an issue or a population. They are focused on a domain of knowledge and expertise that deepens by interacting on an ongoing basis. They develop a shared practice by working together on problems, solutions and insights, and building a common store of knowledge (Wenger, 2002). [redacted] providers who opted into the Community of Practice are those most interested and prepared to serve families who are at-risk of losing custody of their children to the child welfare system as well as families who have already lost temporary custody and are working to reunify with their children. By joining the Community of Practice, [redacted] providers signaled to DHS, Community Care and others that they are willing to: 1) partner to adapt service delivery to meet the needs of child

welfare-involved children, parents, and families; 2) make their [redacted] staff available for specialized training, meetings and other events related to the Community of Practice; and, 3) partner in an evaluation related to this work.

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

    - The agency's internal quality assurance team will continue to monitor practice improvements and provide feedback to leadership and casework staff.

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

    - Children's Hospital of Pittsburgh recommended that law enforcement utilize the interview rooms at CHP when conducting interviews, as these rooms are child-friendly and may ease anxiety of the child.

    - The Review team reviewed national and local data on gun violence, including accidental shootings.

Department Review of County Internal Report:

The County provided a detailed internal report. The report includes identifying the goals of the Act 33 review and thorough recommendations discussed by the review team.

Department of Human Services Findings:

- County Strengths:
    - The County presented a collaborated Act 33 meeting with medical, law enforcement and provider agencies. The County was prompt in responding to the report.

- County Weaknesses:
    - The County noted it did not complete an initial safety assessment within the mandated timeframe.
    - The County noted limited collateral contact in regards to prior referrals and completing limited documentation.

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

  None

Department of Human Services Recommendations:

The Department agrees with the County recommendation to, at a minimum, have a discussion during an assessment when a firearm is noted to be in the home and the family's method regarding safe storage and properly securing a firearm.