pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Jonmarquis Stepich

Date of Birth: 01/01/2008
Date of Death 06/23/2016
Date of Report to ChildLine: 06/20/2016
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Allegheny County Office of Children, Youth and Family Services

REPORT FINALIZED ON:
11/16/2016

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.

Allegheny County has convened a review team in accordance with the Child Protective Services Law related to this report. The county preliminary review team was convened on 07/22/2016 followed by the larger review team meeting on 08/30/2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Jonmarquis Stepich	Victim Child	01/01/2008
[redacted]	Mother	[redacted]/1985
* [redacted]	Father	[redacted]/1988
[redacted]	Sibling	[redacted]/2003
[redacted]	Half-sibling	[redacted]/2012
[redacted]	Father of Zy'Mir	[redacted]/1978

* 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 current case records pertaining to the victim child's family. WERO staff participated in the Act 33 meeting that occurred on 07/22/2016 and 08/30/2016 in which the Allegheny County caseworker, medical professionals from the local hospitals, the Assistant District Attorney of Allegheny County and law enforcement were present and provided information regarding the incident.

Children and Youth Involvement prior to Incident:

Allegheny County Children, Youth and Family Services had no active involvement nor was there prior involvement within the past 16 months with the family.

Circumstances of Child Fatality and Related Case Activity:

On 06/20/2016, Allegheny County Office of Children, Youth and Families (CYF) received a child protective services (CPS) report of suspected child abuse regarding an 8-year-old, male child who was reportedly found unresponsive at his family's home in the early hours of 06/20/2016. The victim child had been transported by his mother and [redacted] to a local hospital and consequently airlifted to [redacted] for further evaluation and treatment. The initial CPS report on 06/20/2016 was registered for serious medical neglect through failure to provide medical treatment/care. It was alleged that the adult caregivers waited three hours before seeking medical attention after finding the victim child unresponsive at 3:00 AM. The presenting caregivers drove the victim child in their personal vehicle to the local hospital at around 6:30 AM. The local hospital evaluated the victim child to be in critical condition, with a life-threatening brain injury and bruising to the chest, back, neck and buttocks. It was unknown at the time of the initial CPS report if the child's injuries were the result of abuse or neglect.

The caregivers were not able to provide an explanation for the injuries at the time of assessment by the local hospital staff. A pediatrician indicated that the victim child's injuries were suggestive of physical maltreatment, and ChildLine certified the report as a child near-fatality on 06/21/2016. The victim child later died at Children's Hospital on 06/23/2016, after being removed from life support. The CPS report was amended on 08/17/2016 to include an additional allegation, causing the death of a child through any act or failure to act, with the mother's paramour named as an alleged perpetrator.

Upon receipt of the report, the county responded to the hospital to assess the victim child as well as ensure safety for the child's siblings. The siblings were examined by hospital staff and were found to show no signs of abuse or neglect. At the hospital, CYF interviewed the mother and biological father of the victim child as well as the victim child's biological brother. Upon interviewing the mother, she reported that the family returned home from an all-day outing in the late evening of 06/19/2016. Upon arriving home, the mother told the victim child to take out the trash and then told him to go to bed. The mother reported that she and the oldest child left the home at about 1:30 AM to go to her cleaning job and when she returned home an hour later the victim child was sleeping in the oldest brother's bed. The mother reportedly showered and watched movies with [redacted]. She stated that she was later awakened by [redacted] who was panicking and telling her they had to go to the hospital as the victim child was [redacted] and not waking up. She stated that she saw no injuries to the victim child, but that he was not waking up. She stated that she got dressed immediately, and they drove him to the hospital. She denied waiting hours to take the victim child to the hospital.

The County and Law enforcement requested an emergency forensic interview to be conducted with the victim child's two siblings on 06/20/2016. A disclosure of domestic violence between the adult caregivers was given at the time of the

interviews. In regards to incidents of violence toward the victim child, there were reports of physical discipline however no hardened disclosure of abuse.

CYF interviewed medical staff from the local hospital who reported the caregivers' accounts of the events that resulted in the victim child's hospitalization. Based on accounts provided by the mother and [redacted], they drove the victim child to the local hospital at 6:30 AM on 06/20/2016, stating they had found the victim child unresponsive at 3:00 AM. According to the medical staff, neither the mother nor [redacted] was able to state why they waited to transport the child. Additionally, the caregivers did not report anything had happened while at home. It was reported that both adults had given similar accounts of the events. A medical evaluation revealed the victim child to be in a coma, with severe head trauma, bruising and multiple scratches on his neck, arm and legs. The physician stated that the hospital performed emergency procedures, intubated the victim child and placed him on a helicopter for transport to [redacted]

At the time of the incident, the victim child was residing in the family home with his mother, two siblings, and the father of the youngest child. The biological father did not reside in the home. After interviewing the biological father at the hospital, CYF approved for the older sibling be placed with his father, who resided in Fayette County. The father and sibling remained at the hospital that night and returned to Fayette County the following day. The youngest child was placed in an agency resource home, due to no immediate kin being located at the time of removal.

On 06/21/2016, Allegheny County CYF requested that Fayette County Children and Youth Services conduct an immediate courtesy assessment of the oldest child's biological father's home, as the father resided in that county. Fayette County CYS responded on the same day as the request and assessed the home and interviewed the father, the oldest child and other adult household members. The physical condition of the home was assessed as appropriate. Fayette County CYS also conducted a substance use screen as a routine component of their courtesy assessment and because several household members appeared under the influence. Three of four adults residing in the home tested positive for substances. During his interview with Fayette County CYS, the oldest child asked to speak to the caseworker about the events on the day of incident. He reported witnessing his [redacted] hitting his brother after the family's return from their all-day outing. He also reported that he heard the victim child breathe and snore in an unusual manner when he fell asleep, which the oldest child reported to his mother. Fayette County CYS worker immediately communicated findings to Allegheny County CYF via telephone and fax. The worker assessed the oldest child as safe in his father's home due to the presence of a fit, willing and able caregiver at the home, while documenting substance use by other adults. The father, the oldest sibling, and other family members later returned to the hospital as the victim child's condition was deteriorating.

Detectives noted conflicts in the accounts provided by the family and continued interviewing family members. Law enforcement later notified CYF that the [redacted] admitted to assaulting the victim child. The police arrested him for

charges associated with causing the injuries to the child. The [redacted] shared with law enforcement that he had fallen over clothing that he had told the victim child to pick up earlier in the day. He then went to wake up the child to pick up the clothing and became angry when the child remained seated on the edge of the bed. At this time, the [redacted] admitted to picking the victim child up around the abdomen and throwing him across the room, attempting to throw the child on the bed. He reported hearing a 'thump'. The victim child then reportedly became "lifeless and began vomiting." CYF completed a visit with the [redacted] at the local jail. He offered no information regarding the alleged maltreatment, stating that everything was chaotic and that he thought the child had a medical condition.

At a [redacted] in Allegheny County on 06/22/2016, the [redacted] from his father's care due to his father's positive substance screen and the [redacted] an agency resource home, separate from his youngest sibling. The [redacted] options for the children.

On 06/24/2016, both [redacted] together with the youngest child's paternal grandparents (mother and stepfather of [redacted]). The court ordered that both children be scheduled for [redacted] and for visits between the mother and children to be supervised by the paternal grandmother. Additionally, the oldest child's visitation with his father was to be supervised in the kinship home.

CYF received two subsequent reports from ChildLine regarding the case. The first referral was regarding the 16-year-old child of the [redacted] and his former spouse, alleging physical maltreatment that occurred five or six years ago. CYF screened out this report, given the age of the allegations and the current safety status of this child in her mother's care. CYF received a supplemental report that alleged observation of [redacted] punching the victim child in the chest at the family home. The [redacted]

Currently both of the siblings remain in the care of the youngest child's paternal grandparents. [redacted] Supervised visits were moved from the home of kin to the kinship provider agency's office, due to father's reported drug dealing and refusal to sign releases of information for behavioral health services. Law enforcement continues their criminal investigation regarding mother as a possible alleged perpetrator. The mother's paramour was arrested and charged in relation to causing the death of a child. He was charged with Recklessly Endangering another Person, Criminal Homicide and Endangering the Welfare of Children.

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;
  Allegheny County CYF demonstrated careful consideration for the surviving siblings' need for stability and emotional wellbeing in their living arrangements by placing the siblings together with kin who are connected to both children. This placement decision mitigated additional trauma and enhanced emotional wellbeing for both boys.

  Allegheny County CYF intake staff, law enforcement and hospital staff adhered to the established Joint Investigative Process to investigate the allegations of maltreatment. Of particular strength was the emergency schedule and completion of forensic interviews for the surviving children.

  Fayette County CYS demonstrated strong collaboration with Allegheny County CYF through their immediate and comprehensive assessment of the oldest child's biological father's home and adult caregiving capacities of all household members. Fayette County CYS documented their assessment, including a substance screen, and immediately shared their findings through telephone contact and in writing with Allegheny County CYF.

  Allegheny County CYF engaged the biological father of the two older children and the paternal kin during the investigation and family services phases of practice, applying the Conferencing and Teaming practice model adopted by the agency.

- Deficiencies in compliance with statutes, regulations and services to children and families: The following challenges were noted by the county, not all of which are deficiencies:

  The oldest child was placed with his biological father prior to completion of a courtesy assessment by Fayette County CYS. That courtesy assessment indicated that father and other household members used illegal substances, resulting in the subsequent removal of the oldest child from father's care and placement in a resource home, without his brother.

  There was some delay in linking the surviving children with grief counseling, as the family considered the first referral agency an inadequate match. However, the family is now receiving trauma-informed treatment.

  Mother was initially not fully cooperative with the child protection investigation and has not demonstrated cooperation with law enforcement. The Review Team discussed mother's lack of cooperation as possible demonstration of her allegiance to the perpetrator and/or her trauma associated with a reported history of intimate partner violence.

The children's kinship caregivers are the youngest child's paternal grandparents (mother and stepfather of the perpetrator.) While the Review Team discussed the strengths of this kinship placement, noting that the children are placed together and with familiar kin, team members also expressed concern that the grandparents may not comply with law enforcement's conditions of no contact between the children and the perpetrator.

The Review Team also noted that paternal grandparents are supervising visitation between mother and the children in the paternal grandparents' home. The Review Team cautioned that contact between children and the perpetrator, as well as mother's possible influence on the children's future testimony, may compromise law enforcement proceedings and, more importantly, may exacerbate harm to the children's emotional wellbeing by forcing them to choose loyalties among family members.

- 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 supports DHS's work associated with enhancement of assessment and planning on intimate and family violence, including contracting with Futures without Violence, a nationally recognized organization that will deliver training for frontline staff and supervisors and provide a Training of Trainers for a core group of agency staff.

The Review Team discussed the use of the term, "by agreement of all parties", reflected on written court orders. In this case, the agency recommended unsupervised visits between the oldest child and his biological father and between mother and her two children under certain conditions and "upon agreement of all parties." The Review Team recommended that CYF and other parties confirm those conditions under which unsupervised visitation would occur.

As in several previous case reviews, the Review Team discussed the latitude given to child welfare agencies in deciding whether to conduct courtesy assessments upon request from other jurisdictions. While Allegheny and Fayette Counties routinely agree to conduct courtesy assessments, other counties often deny county requests. The Review Team noted that refusal to conduct such an assessment may result in inadequate assessment of caregivers and pose a disservice to families who otherwise could be supported within the child protection safety net. The Review Team recommended that the state review regulatory language related to courtesy assessments and circumstances under which counties may refuse another

jurisdiction's request. (Please note Fayette County CYS worked in conjunction with Allegheny County CYF on this case).

The Review Team recommended that CYF consider filing for aggravated circumstances (Section 6302 of the PA Juvenile Act) with the Court to determine whether reasonable efforts to preserve and reunify the family will be made. The facts of this case appear to support filing for aggravated circumstances, as the deceased child was the victim of physical abuse, resulting in serious bodily injury or aggravated physical neglect by the parent.

The Review Team recommended consideration for a Court Appointed Special Advocate (CASA) for the surviving siblings.

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

  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.

  The Review Team recommended enhanced communication between child welfare and the criminal justice system when parents and caregivers of children are involved with both systems. Lack of cooperation or adherence to investigation practices in either system can become an impediment for the system being rebuffed. Open communication of both systems when this occurs to ensure the protection of children who may be at risk and to coordinate a dual-systems' response.

  The Review Team recommended continued review and reinforcement of the established joint investigative protocol developed by the Office of the District Attorney, law enforcement and child welfare agencies.

Department Review of County Internal Report:
The County submitted their report in a timely manner within the required 90 day timeframe. The county report was reviewed and the Department is in agreement with their findings

Department of Human Services Findings:

- County Strengths: The County conducted a complete and thorough assessment of the family; they immediately ensured safety of all of the

children, and obtained a court order to place the children. They also requested and received all documentation concerning records on this family.

- County Weaknesses: No additional challenges or weaknesses above what the county identified in their report.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There are no areas of non-compliance by the county.

Department of Human Services Recommendations:

The Western Region appreciates the sheer volume of child fatality and near-fatality reports generated in Allegheny County alone. Although no report is any less distressing, the events of this fatality appeared to weigh heavy on some of those involved on the review team. As the Department works to assess and alleviate the effects of vicarious and secondhand trauma on staff, it would also be recommended to not lose sight of the county employees who also experience such effects, many times on a much more direct level. Providing the necessary supports to our county child welfare agencies should be a high priority for the Department.