pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Isaiah Brooks-Leonard

Date of Birth: 09/20/16
Date of Death: 02/06/17
Date of Report to ChildLine: 02/06/17
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:
07/17/2017

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.

Allegheny County Office of Children, Youth and Families Services (ACOCYF) did convene a review team related to this report due to the fact that this case was determined to be "Indicated" within 30 days of the oral report being received by ChildLine. The internal county review occurred on 03/09/17 with the full county meeting occurring on 05/15/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Isaiah Brooks-Leonard	Victim Child	09/20/2016
[redacted]	[redacted]	2000
[redacted]	[redacted]	1999
[redacted]	[redacted]	1986

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children Youth and Families (WRO) obtained and reviewed the records given by ACOCYF on this case and attended the county review team meeting on 03/09/2017 and the full county meeting on 05/15/2017.

Children and Youth Involvement prior to Incident:

On 07/25/2015, ACOCYF received a [redacted] report with the [redacted] as the alleged victim for alleged sexual maltreatment by [redacted]. Due to the allegations, [redacted] was [redacted]. The allegations were [redacted], however [redacted]. [redacted]. The victim child was released to the care of [redacted] and remained [redacted] with her. ACOCYF filed a [redacted] petition for the newborn on 10/13/2016. The [redacted] petition was heard in front of the Court on 11/15/2016 and was dismissed. The Judge ruled that ACOCYF did not present evidence to support that a finding of [redacted] of the victim child at that time. On 01/12/2017 [redacted] was established and [redacted] had [redacted] first day visit with the victim child on 01/15/2017 at the agreement of [redacted] but unbeknownst to

ACOCYF. [redacted] had another day visit and then [redacted] first weekend visit was on 02/05/2017.

[redacted] has had four previous referrals to ACCYF. In February 2003 the agency received a referral that [redacted] who was three at the time, and [redacted] (the [redacted] of the victim child) did not have stable housing. The referral was not accepted for services. Two other referrals were received in August 2009 and April 2016 both alleging physical maltreatment towards [redacted] and [redacted] younger sibling. These reports were unsubstantiated and ACCYF did not accept the cases for services. In May 2015 ACCYF received a referral that [redacted] (who was a teenager) was sexually active, this referral was screened out.

Circumstances of Child Fatality and Related Case Activity:

On 02/06/17, ACOCYF received a [redacted] referral that the victim child had been brought by ambulance to [redacted] in full cardiac arrest and was pronounced deceased at 04:33 AM after 28 minutes of CPR. Post mortem it was discovered that the victim child had a 3-4 cm bruise to his right cheek bone, a contusion to his sacroccocygeal, right hip, finger marks on his ankles and a crusted abrasion on his left nostril. An autopsy was performed and upon further examination the child was noted to exhibit head and face trauma as follows: Contusion on the right cheek, scabbed abrasion on right forehead, abrasion on left forehead, abrasion versus drying artifact on left nose/left philtrum, multiple regions of subgaleal hemorrhage on posterior scalp and laceration of the frenulum.

[redacted] reports that [redacted] was co-sleeping with the infant and woke up around 03:40 AM and found the child not breathing. [redacted] resides in the home with [redacted]. [redacted] stated that [redacted] carried the child from the attic to the second floor where [redacted] was and handed [redacted] the baby and [redacted] performed Cardiopulmonary Resuscitation (CPR) while [redacted] called 911. The victim child was transported by emergency medical technicians (EMT) to University of Pittsburgh Medical Center (UPMC) McKeesport Hospital. Emergency Room (ER) staff performed CPR on the child for 28 minutes, child regained a pulse once but was pronounced deceased at 04:33 AM. [redacted] was interviewed by Allegheny County Homicide Detectives and an Intake Caseworker from ACOCYF. [redacted] had no reasonable explanation for the victim child's injuries. The victim child had previously been in the care of [redacted] at [redacted] until 02/05/2017 when [redacted] got child for [redacted] first overnight visit. According to [redacted], the victim child was free from injury on 02/05/2017 when he left for the visit with [redacted].

[redacted] stated during [redacted] interview with ACOCYF that [redacted] did not have a pack n play or crib for the victim child to sleep in. The victim child slept with either [redacted] in their respective beds. [redacted] stated the same information as [redacted] advised that [redacted] did not have money to obtain the appropriate supplies like a crib or pack n play for the victim child. [redacted] reported that on 02/05/2017 [redacted] fed the victim child a bottle, gave him his binky and went upstairs to bed around 10:00 PM. Around 12:48 AM [redacted] came into

[redacted] room, re-swaddled the baby, and repositioned him on [redacted] pillow and left. [redacted] woke up around 3:05 AM and checked on the victim child and found him not breathing. [redacted] advises that [redacted] grabbed the victim child lightly by the back of his head and shook him gently to try and get him breathing and then [redacted] shook him a little harder. [redacted] then picked up the victim child and ran him down to [redacted], who performed CPR until the ambulance came. [redacted] noted that [redacted] may have given the victim child his binky at some point during the night as a way to keep the child from crying but [redacted] is unsure.

On 03/29/2017 ACOCYF submitted [redacted] on [redacted] for the injuries but [redacted] as at the time the report was due, the medical examiner had not yet made a determination of cause of death.

The medical examiner on 05/30/2017 determined that the victim child's cause of death was suffocation and the manner homicide. [redacted] was arrested on 05/31/2017 on one count of criminal homicide and is being held at the county jail. A [redacted] case was opened [redacted] as a child after the death of the victim child but before [redacted] was charged to date no referrals have been submitted for services to the family.

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;

  The Review Team commended the intake caseworker on her efforts to obtain medical records from the infant's pediatrician as well as from the local hospital to which the infant presented. The intake caseworker mailed the legally executed release of information to these agencies, as well as presented in person to obtain information when the agencies did not respond to requests for information

  The Review Team commended the former active caseworker on her demonstrated engagement with [redacted] and the frequency with which she visited [redacted] infant.

  The intake caseworker contacted law enforcement immediately after case assignment to ensure adherence to the joint investigative protocol. The intake caseworker conducted a thorough review of the circumstances of the infant's death and provided detailed documentation in the record. CYF received a [redacted] report for the [redacted] and [redacted] family after the infant's death, as the infant was at [redacted] home at the time of his death and there were other minor children residing in that home. The assigned [redacted] investigative and intake caseworkers completed a joint home visit; while the intake worker interviewed family members to complete the [redacted], the active caseworker met with

the family to assure the children's safety in the [redacted] home. The children were assessed as safe, and the family was [redacted]. According to interviews with [redacted], ACOCYF was in the process of reconsidering the refiling of a [redacted] for the infant because of newly identified risk factors ([redacted] AWOLs with [redacted] baby) prior to the infant's death.

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

  Practices by ACOCYF and the group care provider reflected a misunderstanding that the court's dismissal of the infant's [redacted] limited these agencies' responsibilities to engage, assess and plan with all family members, including [redacted].

  The Review Team addressed challenges with the identification of [redacted] and the timing of [redacted] in this case. While [redacted] was identified early in the life of the case, [redacted] was engaged or assessed. The rationale was that the court had dismissed the infant's [redacted] and because [redacted] was reportedly initially ambivalent about [redacted] involvement. Records and interviews confirmed that the agency was aware of [redacted] as the [redacted] as early as November 2016, at the time that [redacted] filed for [redacted]. The ACOCYF paralegal staff began a diligent search for [redacted] at that time. A court order from November 2016 also named [redacted] as the [redacted] and [redacted] which was [redacted] in January 2017. Although [redacted] considered visitation as early as November 2016, [redacted] made the decision to allow unsupervised contact in January 2017, after [redacted]

  The Review Team addressed the absence of an effective team that included [redacted], professionals involved [redacted] and other informal supports identified by [redacted] and that worked together toward agreed-upon goals.

  The Review Team identified that Safety Assessments were not completed in accordance with state regulations.
  - The former active caseworker conducted an initial Safety Assessment for the infant approximately three weeks after his birth, instead of within the 72-hour initial timeframe. The most recent Safety Assessment for the infant had been conducted in December 2016 and was identified as a "Case Closure" Safety Assessment; however, his case was not closed until after the fatality. The Case Closure Safety Assessment was completed two days following [redacted] first abscondence with the infant, and the infant was assessed as safe in [redacted]
  - The former active caseworker conducted a final Risk Assessment in late December 2016, following [redacted] first abscondence with the

infant, with a risk rating as low and lacking information related to [redacted] initial abscondence with the infant. The Risk Assessment documented [redacted] but did not rate risk factors applicable to [redacted]. The caseworker also identified that, "the judge ordered closing due to there not being any issues." There was no information identified in the court orders that reflected the court's ordering CYF to close their case for the infant and [redacted].

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

  The Review Team recommended early identification, engagement and assessment of all [redacted], regardless of their ages and relationships to [redacted], to ensure thorough and timely assessments of family systems and to identify any safety or risk factors related to visitation or custody decisions. While ACOCYF had knowledge of [redacted] identity as early as November 2016, ACOCYF did not assess [redacted] and [redacted] to determine their abilities to safely care for the infant, including adequate safe sleep arrangements. The former active caseworker shared that she and [redacted] had several conversations about whether [redacted] would allow [redacted] to visit with the infant; however, [redacted] was initially ambivalent about contact and delayed any decision until [redacted] in January 2017. The court decision to dismiss [redacted] was a key factor in ACOCYF's decision to allow [redacted] to independently make decisions about [redacted] contact with [redacted] child, without ACOCYF's assessment of the [redacted] home and caregivers. ACOCYF reportedly was unaware that [redacted] made a final decision to allow [redacted] and [redacted] to visit with the infant at their home. The Review Team recommended that ACOCYF staff adhere to practice standards to conduct collateral contacts to ensure that comprehensive and relevant information is obtained in a timely manner to support screening and practice decisions.
    - In this case, physical health records and interviews confirmed that the infant was [redacted]. There was no documented collateral contact with the infant's [redacted], as the former active caseworker viewed the adjudication dismissal as limiting the agency's authority to obtain collateral information related to the infant.
      i. There was no referral to [redacted] for the infant.

  The Review Team discussed the need to adhere to the agency's Conferencing and Teaming practice model and to state regulations to ensure that ongoing assessment, teaming, planning and monitoring occur.
    - Assessment and Planning:
      1. The newly assigned active caseworker had updated the Family Advocacy Support Tool (FAST) in accordance with regulatory timeframes; however, the assessment did not reflect updated information since the infant's birth nor current case events.

2. In this case, the most recent Family Plan, dated after the infant's death, reflected outdated goals that had been established prior to the birth of the infant.
3. The Review Team recommended routine documentation include all family members, including the infant, [redacted]. This documentation standard applies to both ACOCYF and providers.

o Teaming:

1. The Review Team recommended that all families served by ACOCYF benefit from a well-formed and functioning team that shares information and works together to assess, understand and plan with all family members.
2. The Review Team recommended that the teaming process include identified informal and formal supports, including all disciplines working with the family, to integrate the perspectives and identify outcomes from each service area. The Review Team specifically recommended that the [redacted] specialists who are co-located within regional offices join the ACOCYF teaming process in this case and others that involve [redacted]

The Review Team recommended reinforcement of practice expectation that ACOCYF file [redacted] for a child who is the subject of a near fatality/fatality and/or a child born to [redacted], as well as consideration for re-filing when the child's situation changes. ACOCYF has drafted a policy related to the filing of [redacted] for [redacted] and will finalize this policy in the near future.

i. ACOCYF filed [redacted] in a timely manner after the infant's birth. Following the court's dismissal of the [redacted], [redacted] absconded with the infant from [redacted] on two occasions, and ACOCYF reportedly was in the process of considering refiling [redacted] at that time, according to the casework staff.

2. The Review Team recommended written clarification on the application of *Reasonable and Prudent Parenting Standards- Pa Act 75 of 2015; Public Law 440 (December 10, 2015) and United States Public Law 113–183 (September 29, 2014.)* These standards detail how [redacted] inform day-to-day decisions about the care of children [redacted]. Decisions are informed by the health, safety and best interests of children while encouraging and supporting emotional and developmental growth. ACOCYF and the provider interpreted the standards as allowing [redacted] to have independent authority to decide

about the infant's care, including contact with [redacted]

- 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.

iii. Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. The Review Team discussed the challenges with timely access to physical health records for the infant following his death. The intake caseworker was unable to obtain the medical records as the records departments of the hospital and pediatrician would not release records without a death certificate, despite the legally-executed release of information, which had been signed by [redacted]. ACOCYF later received the records after intervention from [redacted].

iv. The Review Team discussed the need for continued recognition of secondary trauma and need for support to direct work professionals and others involved in practice and case review following a child fatality. The Review Team recommended that secondary trauma education and supports be readily available to professionals.
   - Allegheny County DHS administrators reached out to various professionals who worked directly with the infant and [redacted] before and after the Act 33 review to provide supports.
   - The [redacted] shared that an outside counseling resource was engaged for [redacted] to assist [redacted] following this infant's death.
   - The Review Team recommended continued public education regarding safe sleep practices and the risk factors associated with bed-sharing with an infant or child.

v. The Review Team discussed the need for continued communication among child welfare, law enforcement and the county Medical Examiner to ensure information sharing and collaboration on complex cases to better understand cause and manner of death as each system works to prevent the likelihood of such outcomes.

Department Review of County Internal Report:

WRO reviewed the Internal Report and found it to be all encompassing with what was discussed as far as strengths and concerns. This case was particularly

complicated and the Department agrees with what was presented in the internal report.

Department of Human Services Findings:

- County Strengths: The ACOCYF Intake department did a thorough and complete investigation of the facts of this case. The interviews were extensive and the contacts were made in a timely manner.

- County Weaknesses: ACOCYF [redacted] against [redacted] to the child [redacted] because [redacted] was not back yet instead of [redacted]. It was noted by a Supervisor that the Law does not allow [redacted] unless there are charges filed which is no longer the case, however the Intake Director noted that it is ACOCYF's policy that they do not [redacted] unless there is criminal charges.

[redacted]ACOCYF did not [redacted] for the victim child after it was dismissed in November 2016 even though [redacted] was placing the victim child at risk by going Absent without Leave (AWOL) from [redacted] and reportedly [redacted]. The victim child was possibly [redacted]

- [redacted] home was never assessed before [redacted] started visiting with the child. ACOCYF advises that they did not know that [redacted] was having visits as they were never informed. There were many safety and risk factors noted for [redacted], including the fact that [redacted] did not want this baby and had made many threatening texts, Facebook messages and snapchat messages asking [redacted]. ACOCYF did not visit [redacted] prior to the home visit to ensure that the victim child's basic needs would have been met [redacted]. ACOCYF contended that they did not know that [redacted] even though [redacted] November 2016. [redacted] should have been assessed at that time.

- There was lack of communication between [redacted] and the ongoing caseworker as to the decisions that [redacted] was making for the victim child. [redacted] stated that they did not know what their responsibility was to notify ACOCYF since the victim child was not [redacted].

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - Per 3490.232 (f) & (g) the county agency shall see the child and visit the child's home during the assessment period. The home

visits shall occur as often as necessary to complete the assessment and insure the safety of the child. There shall be at least one home visit. (g) The county agency shall interview the child if age appropriate, and the parents or the primary person who is responsible for the care of the child. The county agency shall also conduct interviews with those persons who are known to have or may reasonably be expected to have information that would be helpful to the county agency in determining whether or not the child is in need of general protective services. In this case, when the victim child was born there is no documentation that ACOCYF assessed [redacted]. From the case record, it appears that there was no contact with [redacted] until after the victim child's death.

- Per CPSL 6375 (j)&(k) If the county agency determines that [redacted] are in the best interest of a child and if an offer of [redacted] is refused or if any other reason exists to warrant court action, the county agency shall initiate the appropriate court proceedings. (k) The county agency shall maintain its responsibility for petitioning the court when necessary for the [redacted] of a child pursuant to 42 Pa.C.S. CH.63 (relating to juvenile matters). In this case, ACOCYF [redacted] of the victim child in October 2016 and it was dismissed in November 2016 by the presiding Judge as there was no evidence presented that the victim child was at risk. However, [redacted] began going AWOL [redacted], taking the baby [redacted] and was allegedly [redacted] and the victim child's [redacted] had concerns for [redacted]. The agency failed to initiate appropriate court action at this point.
- Per 3490.235 (g) When a case has been [redacted], the county agency shall monitor the safety of the child and assure that contacts are made with the child, parents and service providers. The contacts may occur either directly by a county agency worker or through purchase of service, by phone or in person but face to face contacts with the parent and the child shall occur as often as necessary for the protection of the child. After the case was opened on the victim child the agency failed to have any contact with [redacted] until after the victim child's death. [redacted] in November 2016 and in January 2017 [redacted]. The agency failed to have any contact with [redacted] or assess [redacted] home.

Department of Human Services Recommendations:

The Department needs to provide to guidance to County and Provider agencies as to Prudent Parent Standards for [redacted]