pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Nyeir' Hardimon

Date of Birth: 10/20/2017
Date of Death: 11/14/2017
Date of Report to ChildLine: 11/14/2017
CWIS Referral ID: [redacted]

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

Erie County Office of Children and Youth

REPORT FINALIZED ON:
04/18/2018

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.

Erie County convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 12/07/2018.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Nyeir' Hardimon	Victim Child	10/20/2017
[redacted]	[redacted]	1995
[redacted]	[redacted]	2015
[redacted]	[redacted]	1994
[redacted]	[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. These include: referral information, medical documentation, family service plans, past referrals, and case contacts. WERO staff attended the Act 33 meeting which was held on 12/07/2017.

Children and Youth Involvement prior to Incident:

Erie County Office of Children and Youth (ECOCY) first became involved with the family on 08/04/2017 after receiving [redacted] stating that [redacted] and [redacted] were living in a homeless shelter. The [redacted] stated that [redacted] was seven months pregnant and [redacted]. [redacted] lacked support from a partner, as [redacted] was reportedly incarcerated and [redacted] unknown. There were also concerns that [redacted] was unable to pay past due bills for utilities, which prevented [redacted] from securing appropriate housing. Per [redacted] staff, [redacted]

[redacted] appeared [redacted] and easily stressed out by [redacted] behavior.

The family was [redacted] on 09/13/2017. ECOCY provided funds to pay the overdue utility bills so that [redacted] could move into a new apartment. After immediate needs were met, ECOCY assisted [redacted] in rescheduling her [redacted] appointments and purchasing beds. Referrals were also made to contracted providers for [redacted], financial assistance, and parenting skills. The ECOCY caseworker completed [redacted] on 09/26/2017 and 10/13/2017 and documented no apparent risk or safety concerns. However, during this time, case notes state that the caseworker attempted to schedule an in-person family team meeting, but that [redacted] was difficult to reach by phone and had cancelled the meeting twice.

[redacted] [redacted] to [redacted] on 10/20/2017. Medical documentation indicated that [redacted] was healthy [redacted] with no documented health problems. It was noted that [redacted] had [redacted] however, [redacted]. [redacted] stated that [redacted] smoked marijuana [redacted] as an appetite stimulant. [redacted] denied any subsequent drug use [redacted].

On 11/02/2017, the ongoing caseworker conducted a home visit with [redacted] present. The caseworker stated that the home was clean and appropriate, and everyone appeared to be doing well. The caseworker documented in her case notes that she discussed the risks related to co-sleeping and the correct use of crib bumpers. [redacted] relayed to the caseworker that [redacted] would sleep in the bassinet. At this home visit, [redacted] agreed to reschedule the family team meeting for 11/09/2017 to meet with contracted providers and complete a service plan. This meeting was cancelled, however, as no one was home at the time of the scheduled appointment.

<u>Circumstances of Child Fatality and Related Case Activity:</u>

On 11/14/2017, ECOCY received [redacted] concerning [redacted]. The referral stated that Emergency Medical Services (EMS) was dispatched to the home at 5:15 AM that morning. [redacted] reportedly found [redacted] not breathing, with blood on [redacted] face and the pillow [redacted] had been sleeping on. After being transported by ambulance to a local hospital, [redacted] received emergency care, but continued to be unresponsive and in cardiac arrest. [redacted] was pronounced dead by hospital staff at 5:55 AM the same day.

Per the intake referral, this [redacted] was registered as a fatality due to the child presenting with blood on his face, inconsistent with symptoms of accidental Sudden Infant Death Syndrome (SIDS). Due to [redacted] being

"extremely distraught," hospital staff could not get a reasonable or consistent sequence of events. In this referral, [redacted] was named as [redacted], as [redacted] role and [redacted] at the time of [redacted] death was questionable. The specific category of abuse was "causing the death of a child through any act or failure to act."

After ECOCY had received the referral, the on-call caseworker was sent to the hospital emergency room to complete interviews and initial risk and safety assessment. [redacted] provided a timeline to the caseworker that [redacted] fed [redacted] around 11:00 PM. [redacted] again checked on [redacted] between 12:30 AM-1:00 AM. At approximately 5:00 AM, [redacted] stated that she again checked on [redacted] and made [redacted] a bottle. When [redacted] returned, [redacted] reported that [redacted] was not breathing, and there was blood coming from [redacted] nose. [redacted] stated that [redacted] then yelled for [redacted] to call 911. When EMS arrived, [redacted] was rushed to the hospital by ambulance.

Later that day, [redacted] participated in an extensive interview with law enforcement at the police station. The county caseworker was present and observed the interview. A more detailed statement was obtained related to the events of 11/13/2017, which police found to be consistent with [redacted] original account. According to [redacted], [redacted] (who often visited the home to help with [redacted]) fed [redacted] and put [redacted] to sleep at approximately 7:00 PM. [redacted] stated [redacted] left the home at 10:00 PM to play cards at a friend's house while [redacted] stayed with [redacted] was reportedly staying at [redacted], and therefore, not present at the time of the incident. [redacted] states [redacted] had one beer and returned home around midnight. [redacted] reported checking on [redacted] after [redacted] returned and feeding [redacted] at approximately 12:30 AM. [redacted] then states [redacted] placed [redacted] on a pillow, and they both went to sleep in the adult bed. [redacted] states that it was not until [redacted] woke up at 5:00 AM that [redacted] observed [redacted] unresponsive with blood coming from his nose.

Caseworkers also observed [redacted] law enforcement interview at the police station. There were some inconsistencies in the stories provided by [redacted] and [redacted] including: (1) if [redacted] went to a friend's house that evening or to [redacted], (2) exactly how much alcohol [redacted] had to drink, and (3) if [redacted] woke up on [redacted] own at 5:00 AM or because [redacted] heard the victim child crying. [redacted] stated that [redacted] interacted with [redacted] that evening when [redacted] returned home and did not observe signs that [redacted] was intoxicated or impaired. [redacted] made the statement to police that if [redacted] did roll over on the victim child, [redacted] did not feel it was intentional.

Later that afternoon, the ECOCY caseworker made a home visit to [redacted] to ensure the safety of 2[redacted]. The caseworker reported that the situation was very "chaotic" due to multiple

[redacted] and police officers going in and out of the home. During this time, the police discovered that [redacted] had tried to hide the bloody pillow in a closet. [redacted] later stated that this particular pillow had sentimental meaning to [redacted] because it belonged to [redacted] recently-deceased [redacted], and [redacted] feared that the police would take it as evidence. [redacted] was initially not cooperative with ECOCY and expressed fear that caseworkers were going to take [redacted]. The caseworkers did eventually manage to interview [redacted] and determine that [redacted] was not at the residence. [redacted] stated that [redacted] was being cared for at a different [redacted] home. Caseworkers then conducted a separate home visit to [redacted] home and assessed [redacted] risk and safety factors. The home was appropriate, and [redacted] agreed to continue caring for [redacted] pending the investigation.

The ECOCY intake caseworker made an additional contact with the Erie Police Department later that day, who relayed additional information from the coroner's officer. The initial autopsy report showed no signs of suffocation or trauma, or any additional information that would suggest abuse or neglect. The initial cause of death was ruled as medical-related, pending the results of the toxicology report. Police stated that this information was consistent with [redacted] and [redacted] interviews; therefore, they did not anticipate any additional interviews would be pursued. Police informed the caseworker that as long as the toxicology reports came back negative, the victim child's death would be ruled as Sudden Infant Death Syndrome (SIDS).

At this time, the [redacted] for [redacted] remains [redacted] The [redacted] remains open. ECOCY reported that the ongoing county caseworker has made continued efforts to engage the family in services, such as [redacted]. [redacted] and [redacted] are continuing to stay at [redacted] home. The caseworker feels that [redacted] is reliable and appropriate, and is currently working with ECOCY to [redacted].

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

- <u>Strengths in compliance with statutes, regulations and services to children and families</u>;

    - Prior to fatality, the Ongoing Caseworker had a conversation with [redacted] regarding the importance of the baby sleeping in the bassinet, not co-sleeping. Also discussed the use of baby bumpers in cribs.
    - Strong family support system.
    - Services have been initiated in the home to include [redacted] and [redacted].
    - Ongoing caseworker has a good relationship with [redacted].

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

  - Statistic was given: 31% of [redacted] smoke through all socioeconomic classes.
  - Not pursued if [redacted] was using drugs. [redacted].
  - [redacted] was not always cooperative. [redacted] was hard to make contact with and to keep scheduled appointments.
  - [redacted]: Why was child not [redacted]?

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

  - Pursue [redacted] for [redacted] in the home. This would give [redacted] stability and give [redacted] time to [redacted] and attend appointments.
  - Utilize family members to elicit help in keeping in contact with [redacted]
  - Pursue Trauma based services for families.
  - Erie County Office of Children and Youth needs to work on the policy/process for trauma based services for caseworkers.
  - [redacted]Erie County Office of Children and Youth needs to address and implement a protocol for quicker response times to see [redacted] and [redacted] when [redacted]

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

  - Pursue a Protocol for completing [redacted] to meet regulatory requirements in the situation of a death/near death.

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

  - [redacted]Further [redacted]
  - [redacted], to include follow up, if [redacted] or concerns that [redacted].
  - Seek further information regarding Specialist who may come to the Erie area one time a month to see patients with high-risk illness.

Department Review of County Internal Report:

The county provided the Department with a detailed internal report. The report includes identifying the goals of the Act 33 review and thorough recommendations discussed by the review team. WERO is in agreement with the findings and recommendations. The County Internal Report was received on 12/21/2017 and WERO also provided written agreement on this date.

Department of Human Services Findings:

- County Strengths:

  ECOCY adequately met all response times associated with the CPS referral. Detailed interviews with the family, hospital personnel, and law enforcement were completed within the first 24 hours of the investigation. All state-recommended assessment tools were utilized and response times met. An organized, comprehensive collection of documentation was made available to the review team prior to the Act 33 meeting. The Department noted particular strengths in the ongoing caseworker's ability to develop a candid and trusting relationship with [redacted]. Despite [redacted] being unreliable at times in regard to meetings and appointments, the caseworker clearly documented her attempts to engage. Caseworker also documented her efforts to inform [redacted] of the risks associated with co-sleeping.

- County Weaknesses: and

  One identified weakness is that neither ECOCY (nor law enforcement) ordered [redacted] or [redacted] to determine if [redacted] was [redacted] at the time of the [redacted] death. During [redacted] police interview, [redacted] admitted to drinking one beer at a friend's house the evening prior, however, this piece of information went uninvestigated. The county was also aware that [redacted] had a recent [redacted], which indicates recent marijuana use. [redacted] may have better indicated whether or not [redacted] created a reasonable likelihood of bodily injury to the child as the result of being impaired.

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

  There were no areas of non-compliance by the county.

Department of Human Services Recommendations:

The Department recommends that child welfare agencies continue to educate families on the importance of safe sleep, per the standards set forth by the National Institute of Child Health and Human Development. Families should

be reminded that per the NIHCHD, a safe sleep environment includes a safety-approved crib (i.e. not in an adult bed, on a couch, or on a chair alone, with [redacted]).

Additionally, the Department recommends that child welfare agencies, law enforcement, and health care providers gain training related to the dangers of [redacted] use in pregnancy. In cases of [redacted] families, [redacted] are often treated with higher concern. However, current research suggests that [redacted] exposure may have serious effects on the [redacted] child's behavior, cognition, and achievement. According to a 2013 study conducted by the American Academy of Pediatrics ([redacted] Substance Abuse: Short and Long-Term Effects on the [redacted], Behnke, M.) [redacted] who are exposed to [redacted] smoke are twice as likely to die from [redacted]. Professional organizations (such as the American College of Obstetrics and Gynecology [ACOG] and the American Society of Addiction Medicine [ASAM]) recommend that all [redacted] with a history of [redacted] are considered for [redacted] and if necessary, [redacted]

Lastly, the Department recommends that child welfare professionals, specifically caseworkers, be offered support to address possible secondary or vicarious trauma that arises following the death of a child. Child welfare agencies statistically have high rates of staff "burnout" which is frequently linked to the emotional exhaustion in working with vulnerable populations. It is important that staff have access to supervision, consultation, professional training, and support groups to manage any potential trauma they have endured related.