



Elaine C. Bobick
Regional Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF CHILDREN AND FAMILY SERVICES
WESTERN REGION
11 Stanwix Street, Room 260
Pittsburgh, Pennsylvania 15222

(412) 565-5728
Fax: (412) 565-7808

REPORT ON THE FATALITY OF:

Kaelin Davis

Date of Birth: June 26, 2009
Date of Fatality: May 31, 2010

FAMILY KNOWN TO:
Family was not known to
Lawrence County Children and Youth Services.

REPORT FINALIZED ON:
January 25, 2011

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Lawrence County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	[REDACTED], 1985
Kaelin Davis	Victim Child	June 26, 2009
[REDACTED]	Half-sibling	[REDACTED], 2003
[REDACTED]	Mothers paramour	[REDACTED] 1987

Notification of Child Fatality:

On May 31, 2010, Lawrence County Children and Youth Services received a report stating that a child, Kaelin Davis, had been brought to the Emergency Room (ER) of Jameson Hospital in [REDACTED] and was considered [REDACTED] on arrival. The mother's paramour brought the child to the ER and left immediately after bringing the child into the hospital. The child was found to have [REDACTED] on the [REDACTED] and there was [REDACTED]

Summary of DPW Child Fatality Review Activities:

The Department was notified of the fatality by Lawrence County Children and Youth Services on June 1, 2010. Subsequently, phone contact was maintained between the Department and Lawrence County. The Department also had contact with Indiana County Children and Youth Services as after the incident, the mother went to stay with her sister in Indiana County.

The case file was reviewed which contained the intake screening form from Lawrence County, the [REDACTED], dictation from May 31, 2010 to June 16, 2010, the

school records for the victim child's sibling and a copy of a newspaper article regarding the [REDACTED] arrest. On September 9, 2010 the coroner's report was sent to the Western Region Office of Children, Youth and Families (WROCYF) by New Castle Police. Please note it took the coroner until August 19, 2010 to make a determination on the cause of death as the child's brain and eyes had been sent to the University of Pittsburgh for testing. Interviews were done by WROCYF via on-going phone calls with the Lawrence County intake caseworker and supervisor, the Indiana County CYS intake caseworker and supervisor, as well as the assigned New Castle Police Detective. A review meeting was held in Lawrence County on September 20, 2010 to review this case.

Summary of Services to Family:

Lawrence County Children and Youth Services referred the case to Indiana County Children and Youth Services (CYS) for an assessment since the mother went to stay with her sister who resides in Indiana County. Indiana County CYS opened for monitoring purposes as the mother was pregnant with the [REDACTED] child.

Children and Youth Involvement prior to Incident:

There was no involvement with the agency prior to this incident.

Circumstances of Child (Near) Fatality and Related Case Activity:

This information is based on the case notes from Lawrence County Children and Youth Services caseworker assigned to the investigation.

On May 31, 2010 at approximately 10pm Lawrence County Children and Youth Services received a phone call from [REDACTED] that an infant had been brought into the emergency room in [REDACTED]. The child was dead on arrival and had [REDACTED] believed the child had been dead for a couple of hours. The mother had left the child in the care of her paramour who left the hospital after dropping the child off, so the name of child was unknown at this time. Photos of the child were taken and the New Castle police were there. The CYS Intake worker asked if there were other children in the home and [REDACTED] did not know, but stated that if there were other children, the police would bring them to the hospital to be checked over and the hospital will let CYS know. The police are still trying to identify all of the parties.

Lawrence County CYS made a phone call to the 911 center around 11:25pm, as they still could not identify anyone.

A [REDACTED] report was received by Lawrence County CYS Intake around 11:30pm with the identifying information for the child, her mother and the

mother's paramour. The report gave more information about the victim child's condition. The child had [REDACTED]. The mother reported that she had left her child in the care of her paramour while she worked. The mother had been contacted by the hospital.

On June 1, 2010, Lawrence County CYC made a phone call to the New Castle Police Department and spoke to a sergeant. The intake caseworker left him a message to return the call regarding the status of the case and to inquire as to whether there were other children in need of a safety plan. The intake supervisor checked to see if there were any previous referrals on this mother and there were none.

The Lawrence County CYC supervisor contacted the police sergeant on June 1, 2010 who stated that there was another child in the family. It was reported that the sibling, age 7, was seen by the police in the middle of the night. Per the police, she appeared healthy and there were no apparent signs of [REDACTED]. CYC's Initial investigation revealed that mother was at work at the time of the incident, and was not involved in the injuries to her child. The mother works at a [REDACTED]. Her paramour [REDACTED] is currently in the [REDACTED] at the hospital. The police reported that the [REDACTED] is from Missouri and has a criminal record. He did time in state prison for robbery and tampering with an airplane. The investigation revealed that he was supposedly babysitting the child at the mother's residence but took the baby to a friend's house from 2 or 3 p.m. until about 9pm. At about 9:15pm the [REDACTED] and his friend allegedly left Kaelin with the friend's aunt and said they would be back in 15 minutes. They did not return and later told the police that they initially went to [REDACTED] but were not hungry so they then went to the housing projects on Grant Street. Meanwhile a neighbor came to the aunt's house to borrow a cigarette, and noticed that the child was unresponsive and rushed across the street to call 911. When the EMT's arrived, they supposedly found the friend's aunt to be visibly drunk. The mother had reported to New Castle Police that her child had a few bruises from being knocked down by a dog previously but could not account otherwise for what had happened to her child.

The WROCYF Program Representative contacted the Lawrence County intake caseworker to obtain additional information and the caseworker informed her that she and her supervisor were leaving to make a home visit to assure the safety of the sibling.

The caseworker and supervisor arrived at the mother's residence unannounced. The mother, the victim child's sibling and a neighbor were present. The mother was visibly distraught over her child's death. She corrected Kaelin's DOB as 6/26/2009. The caseworker asked the mother if the little girl present was the child's sibling, and she said "no." The mother stated that her daughter lived with

her maternal aunt in Indiana County. She did not know the address but provided a phone number. As they spoke some more, the mother said she thought she had answered differently as the child was actually her daughter and that she was visiting for the weekend and she would be going back to the aunt's today. The mother was crying the whole time during the visit. She was asked if Kaelin had any bruises on her last time she saw her. The mother said only one on her forehead because the puppy had knocked her over onto the cement floor. The mother said that her paramour had watched Kaelin before and had never hurt her, and that he is usually the babysitter. The mother said her other child was at her stepmother's house in Pittsburgh the whole weekend and was not there when the incident happened. The sibling appeared clean and well taken care of, and there were no marks or bruises on her. She played with the puppy during the visit and appeared to have a good relationship with her mother. The sibling did not disclose any [REDACTED]. The mother said her paramour was from Missouri.

The mother said she had gone to work about 1:00 pm because she had to walk to work. She had laid Kaelin down for a nap before she left. She saw her again about 4:00 pm when her paramour and Kaelin stopped by the store to see her. The child appeared normal. Her paramour told her they were going to his friend's house. The mother said that when her paramour drinks, he has a short temper but he was not drinking that day. At 10:15pm when she was done with work, she walked over to the house saw the police there and they told her what happened.

Another Lawrence County CYS caseworker said that [REDACTED] and provided the following information to her on June 1, 2010. [REDACTED] had gone to the hospital to sit with the victim child's mother, and when her phone rang she answered it stating that it was the [REDACTED] calling to see how the child was doing. She refused to give him any information so he handed the phone to his friend. The friend stated that he witnessed the [REDACTED] hold the baby up in the air by her arm and drop her on her head, and that at the time the [REDACTED] thought this was funny. Later, the [REDACTED] came to the hospital and was told to leave. The [REDACTED] then threatened to kill his friend and himself and left the hospital. It was at this time that he was [REDACTED] for [REDACTED] observation.

The caseworker contacted the school that the sibling attended to inquire about her attendance records. On 06/2/10 the agency received anonymous information the mother is pregnant with the [REDACTED] child and she was allegedly calling the hospital to talk to him. The caseworker then made a phone call to the police sergeant who had also heard that she is pregnant and is calling the [REDACTED]. The mother informed the New Castle Police sergeant that her child's funeral is scheduled to take place in Indiana County. The mother reported that she was currently in Indiana County to be with her family and make the arrangements. He obtained the specific address of where the mother is staying as he may have to

obtain an additional statement from her. The caseworker was informed that the [REDACTED] was not yet arrested as he was still [REDACTED] but there were plans to arrest him upon [REDACTED]. The sergeant reported that the investigation was ongoing as additional interviews needed to be completed. The sergeant also reported that the cause of death is inconclusive at this time. There was [REDACTED]

[REDACTED] to all statements obtained to date, the injuries had occurred prior to [REDACTED] taking the child to his friend's aunt's house. A neighbor of the aunt had reported coming to the aunt's house to get cigarettes and he witnessed that the child was whimpering and fussy, and that the [REDACTED] was "mean" towards the baby, as he witnessed him throw a blanket over the baby's head and shove a bottle into her mouth. It was reported that about 15 to 20 minutes later, there was no noise and the baby was unresponsive so the neighbor ran across the street and called 911. The sergeant also reported that the child had been on the couch the whole time which was 3 to 4 hours; she had one bottle, no other food or a diaper change. The [REDACTED] had left with his friend to go get something to eat shortly after arriving with the baby and he never came back for her.

On 6/3/2010 the Lawrence County CYS caseworker made a visit with the supervisor to meet with the mother's friend who stated that Kaelin had several bruises on her face when she last saw her. That was approximately 3-4 days before her death. She said that the [REDACTED] was very mean to the children and to their mother. She also stated that she had witnessed the [REDACTED] hit Kaelin at times.

The agency staff then made a home visit to the mother's neighbor. She said that the mother is a "good mother and would never hurt her child". She stated that she was aware that the [REDACTED] had a temper and they were trying to get her away from him. She acknowledged knowing that the mother was pregnant with the [REDACTED] baby, and that the mother had been in Indiana County with her family and was planning to return home the beginning of next week.

The Lawrence County CYS caseworker and supervisor attempted to make an unannounced home visit on 6/8/2010, but the mother was not home so a note was left for the mother to contact the agency.

On 06/11/10, the agency received a phone call from the mother who reported that she was staying with her sister in Indiana County and plans to stay there permanently. She provided an address and phone number and provided the information regarding the school district that her other child will attend.

On 06/15/10, Lawrence County CYS made a referral to Indiana County CYS requesting that an assessment be completed on the maternal aunt's home that the mother and her daughter are currently residing.

The following is information regarding the notes of the assigned WROCYF program representative:

On 06/18/2010, the Department contacted Lawrence County to inquire as to whether a referral was made to Indiana County CYC and it was reported that the referral was made on 6/15/10. At this point, the program representative contacted Indiana County and spoke to the assigned intake worker. The caseworker reported that a home visit had been made to see the mother and her child on 6/16/2010, and it was confirmed that the mother is pregnant with the [REDACTED] child and is due 02/2011. The mother is residing with the maternal aunt and her child is currently staying with her father in New Castle. It was also reported that the [REDACTED] is staying at [REDACTED] in Lawrence County.

On 06/21/2010, the WROCYF program representative contacted the New Castle Police Department for an update on the case. The sergeant reported that charges cannot be filed until they receive the final autopsy report, as the initial autopsy was inconclusive.

On 06/22/2010 the WROCYF program representative contacted the New Castle police sergeant to obtain an update regarding the autopsy. The sergeant reported that the child's brain and eyes were sent to the University of Pittsburgh for further evaluation, and the results have not come back yet. If the cause of death is natural causes, the [REDACTED] will be charged with aggravated assault, if trauma was the cause, he will be charged with homicide.

On 07/8/2010, the WROCYF program representative again contacted the police sergeant who stated that the District Attorney has advised that the [REDACTED] not be charged until the results come back from the coroner.

The WROCYF program representative also contacted Indiana County CYC and spoke to the assigned intake supervisor who reported that the child's sibling was seen on 6/22/10, and that a safety assessment was completed. The agency planned to go out to see the child again. It was also reported that the intake assessment was still in process.

On 08/12/10 the WROCYF program representative contacted Lawrence County CYC and the caseworker reported that the [REDACTED] had not yet been arrested, and that they have not received a copy of the autopsy report. The New Castle Police Department was then contacted and validated the above information.

On 09/8/10 the WROCYF program representative saw in a newspaper article that the [REDACTED] had been arrested for homicide. Contact was then made with Lawrence County CYC and the New Castle Police and neither party had yet to receive the final coroner's report.

On 09/9/10 the WROCYF program representative received a telephone call from the New Castle police sergeant who stated that the [REDACTED] had been located in Missouri, and that he was being extradited back to Pennsylvania as the cause of death was [REDACTED] and the death was determined to be homicide. The sergeant faxed a copy of the final autopsy report.

On 09/10/10 the WROCYF program representative spoke to the caseworker and supervisor from Indiana County CYS who stated that they assessed the safety of the sibling 6/22, 7/30 and 8/2/10, and she was deemed to be safe in the care of her mother. The case was accepted for services to continue to monitor the situation as the mother is pregnant with the [REDACTED] child.

On 09/20/10 the WROCYF program representative attended the child death review was at Lawrence County. The final status determination of the [REDACTED] investigation was [REDACTED] on 09/12/10 as the death was the result of [REDACTED]. The [REDACTED] was charged with homicide and remains in jail to date.

Current Case Status:

On 02/14/11 the Department spoke to Indiana County CYS Supervisor who reported that the case remained open as the mother had a baby girl on 01/11/11. This is the [REDACTED] baby. The case was open for monitoring but has been closed as the mother is meeting the needs of her daughters. Home visits had been made monthly with no issues noted.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

- Strengths: Lawrence County CYS identified they believe they were in compliance with all statutory and regulatory requirements.
- Deficiencies: Lawrence County CYS did not identify any deficiencies.
- Recommendations for Change at the Local Level: Lawrence County CYS made no recommendations.
- Recommendations for Change at the State Level: Lawrence County CYS stated collaboration among CYS and social service providers should continue to maintain prevention programs in order to identify at-risk families.

Department Review of County Internal Report:

The internal report provided by the agency was submitted by the facilitator of the agency's review team. The Department agrees with the content of the recommendations made in the report in that the agency recommends that CYS and social service providers should continue to maintain and prevention programs i.e., Parents As Teachers, Early Head Start, Head Start, and Nurse-Family Partnership for at-risk families. Assist local community organizations in identifying and referring at-risk families and developing additional promising practices or blue print prevention programs.

The report submitted was for two separate child deaths, with this child's date of death being May 31, 2010, and the other death being [REDACTED]. The Department is concerned that there is no indication that the agency administrator reviewed this report. It is also concerning that the agency combined the reports as opposed to completing an individualized report for each child.

Department of Public Welfare Findings:

County Strengths:

- The agency began the [REDACTED] investigation within the required time-frames.
- The dictation was detailed.
- Lawrence County CYS had immediate contact with law enforcement.
- Lawrence County CYS spoke to the necessary collaterals as part of the [REDACTED] investigation.

County Weaknesses:

- Several requests were made to Lawrence County regarding the need for the [REDACTED] record to be provided by the Department. Despite these request, the agency did not provide a copy of the entire file as required, as the following information was never provided: [REDACTED] notification letters to all required parties; [REDACTED] letters; 10-day supervisory log; safety assessment; and the risk assessment.

Statutory and Regulatory Areas of Non-Compliance:

- 3490.55(F) (1) (2) (i)-(vi) which is a violation of Bulletin number 3490-08-02, Implementation of Act 126 of 2006 Amending the CPSL: No photo was taken of the sibling as required. This is of particular concern given the fact that when the agency saw the sibling the next day the mother initially denied that the child present was her daughter, but then the dictation reflects that it was the sibling. The documentation provided does not reflect that the agency staff spoke to the sibling alone to ascertain that she

was indeed the sibling. At the time of the investigation, the child was seven years old and was certainly old enough to be interviewed.

- 3490.55 (b) (2): the county failed to do a safety assessment on the sibling.
- 3490.232(d) (1-4): the county failed to do a risk assessment on the sibling.
- 3490.401: the county failed to comply with the Inter-county transfer of cases when the mother and child moved from Lawrence County to Indiana County. The agency did not have a photograph to provide Indiana County to ensure the child was indeed the sibling.
- 3490.61: The agency did not provide a supervisory log which is required at least every 10 days during the [REDACTED] investigation.
- 3490.58: The agency did not provide copies of the required notification letters regarding the [REDACTED] investigation which also contains the subject's rights.

Department of Public Welfare Recommendations:

The Department of Public Welfare recommends the following for Lawrence County CYs: the agency needs to review their policy regarding the implementation of Act 33 of 2008 to ensure future compliance; the agency needs to have individual reviews regarding fatalities and near fatalities, and provide the Department with an individualized report that is specific to the individual situation; the administrator needs to review the reports required prior to sending them to the Department; the agency needs to review its policy regarding the need to photograph children and there needs to be supervisory oversight to ensure that photos of children are taken; the agency needs to comply with providing the Department with the entire [REDACTED] file regarding near fatality and fatality investigations; and, the agency needs to review its policy regarding the safety assessment and risk assessment completion, and there needs to be supervisory oversight of these processes.