



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Lyric Quinn

Date of Birth: July 7, 2011

Date of Death: December 12, 2012

Date of Oral Report: December 7, 2012

**FAMILY KNOWN To:
Lawrence County Children and Youth Services**

REPORT FINALIZED ON: 07/19/2013

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. 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. 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.

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 not convened a review team in accordance with Act 33 of 2008 related to this report because the child's fatality was determined to be accidental and an [REDACTED] report was submitted to ChildLine within 30 days of the receipt of the report of suspected abuse which was filed at the time of child's hospitalization.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Father	[REDACTED] 1990
[REDACTED]	Mother	[REDACTED] 1982
Lyric Quinn	Subject Child	07/07/2011
[REDACTED]	Half Sibling	[REDACTED] 2002
[REDACTED]	Half Sibling	[REDACTED] 2006
[REDACTED]	Half Sibling	[REDACTED] 2009
[REDACTED]	Sibling	[REDACTED] 2012
[REDACTED]	Maternal Grandmother	[REDACTED] 1959
[REDACTED]	Maternal Aunt	[REDACTED] 1992
[REDACTED]	Boyfriend of Maternal Aunt	Unknown
[REDACTED]	Maternal Aunt's Child	[REDACTED] 2011

Notification of Child Near/ Fatality:

On 12/07/2012 [REDACTED] that Lyric Quinn had been transported to the hospital by Emergency Medical Services because she was found not breathing at home. She was admitted, [REDACTED], and transferred to the [REDACTED]. The hospital conducted a CT scan, which did not reveal evidence of trauma. The reporter informed [REDACTED] that the child's condition appeared to be the result of a suspicious event. The report was [REDACTED] as a Near Fatality by [REDACTED]. Lawrence County Children and Youth Services was then notified of the report. On 12/12/2012 physicians at [REDACTED] advised the family that the child was not exhibiting any brain activity; following [REDACTED] and consultation with the family, the child was removed from life support and died on the same date.

Summary of DPW Child Fatality Review Activities:

Upon notification of the near fatality the assigned program representative from the Western Regional Office Children Youth and Families contacted the assigned Lawrence County caseworker and obtained case record material pertaining to the subject child and her family. Subsequent to the child's death the regional office was notified by Lawrence County Children and Youth Services that after consulting with staff at [REDACTED] and local law enforcement, the agency had submitted a report to [REDACTED] on January 3, 2013 with a status of [REDACTED]. The agency's [REDACTED] investigation had determined that based on the available evidence the child's death was not attributable to [REDACTED] by her caretakers. Consequently the agency did not conduct a fatality review meeting.

Children and Youth Involvement Prior to Incident:

The [REDACTED] family was initially referred to Lawrence County Children and Youth Services (CYS) on 10/27/2008; that referral was closed at intake when the mother agreed to obtain support services from a community provider.

On 01/16/2009 [REDACTED] contacted Lawrence County CYC to report that the family's situation required CYC involvement. According to the referral source, home conditions presented a potential health and safety risk to the mother's two young children and the mother was approximately 8 months pregnant. The referral [REDACTED] reported it had discussed its concerns with the mother and she was in agreement with CYC intervention. Lawrence County CYC accepted the family for services on 01/22/2009 and has provided ongoing services since that date.

The initial objective of agency intervention was focused on improving the living conditions in the family home. Within 3 weeks of accepting the case the mother gave birth to her third child on 02/07/2009. The assigned worker visited the family frequently to ensure mother's maintenance of the family home was adequate and that she was meeting the children's medical needs. Although the mother agreed to objectives established in the Family Service Plan (FSP), she had difficulty in following necessary steps to ensure attaining them; additionally the agency received reports that the mother might be using illegal drugs. The agency referred the mother for [REDACTED] to which she voluntarily agreed. The children were also receiving [REDACTED]

Between the dates of case acceptance in 2009 and 04/20/2010 the caseworker monitored the mother's care of children through consistent home visits and maintained routine contact with other providers who were extending services to the family. Despite efforts to engage the mother in enhancing home conditions and working with the providers who were attempting to help her and her children, the home situation remained marginal at best. On 04/20/2010 the agency was informed that the mother had [REDACTED]; immediately thereafter a home visit was conducted. The caseworker determined that the mother had not made adequate arrangements for the care of her children while [REDACTED]

The children were placed with agency resource families, as efforts to locate a suitable kinship home were unsuccessful. A visitation schedule was established which the mother generally adhered to. On occasion, however, the mother called the caseworker to report she was having transportation difficulties and was requesting to reschedule visits at the last minute. In most of those instances, the caseworker would adjust his schedule and transport mother to the visits to avoid disappointing the children. The quality of the mother's visits with her children was initially inconsistent; she focused attention on unsubstantiated concerns that the resource mother was not providing adequate care for her children and attempted to elicit complaints from the older children that they were being mistreated. Additionally the mother was uncooperative in participating [REDACTED] By November of 2010 the mother became more collaborative related to visitation. She also was able to demonstrate compliance with the goals established by her [REDACTED] She was able to locate housing and maintain adequate living conditions in the home. Visits were therefore expanded to extended visits in the family home. Once the agency determined the mother was able to adequately meet the children's needs during visitation, reunification of the children with the mother, [REDACTED]

Between 01/03/2011 and 09/09/2011 the children remained in the mother's care. During this interval the mother also gave birth to Lyric, her fourth child and the subject child of this report, on 07/07/2011. There is no mention in the case record dictation of efforts made to monitor prenatal care the mother was receiving or to include this child in the FSP following her birth. The agency did make arrangements for the family to receive support services from several community providers: two of the children were [REDACTED]; one of the children was assigned a [REDACTED] and [REDACTED] continued to provide support to the family. The case dictation reflects that living conditions in the home were marginal; the home was frequently messy and dirty. The mother made repeated promises to the caseworker to clean things up but did not do so. In late July the mother moved her family into the home of the maternal grandmother; a maternal aunt with her child was also residing there. Based on the case dictation this move was apparently made because of violence in the community where the mother was living. The agency received a report that living conditions in the grandmother's home were overcrowded and deplorable. An attempt to evaluate that report on 08/01/2011 was blocked by the aunt who refused to allow the worker into her home. At that point the agency attempted to help the family move into another residence by contacting the [REDACTED] on the mother's behalf. Those efforts were unsuccessful.

On 09/09/2011 the agency was contacted by local police who had responded to a call to the family residence. The police requested that the agency [REDACTED] [REDACTED]. According to the police housing conditions were unacceptable; there were maggots and roaches infesting the house. Additionally police had confiscated illegal weapons and arrested the father of Lyric. [REDACTED]

[REDACTED]. A diligent search for suitable relatives was pursued; however none were identified and the children remained in agency resource homes.

From September 2011 until May of 2012 all the children remained in care while the mother worked on achieving FSP objectives. In May the two older children were returned to the physical custody of the mother, in June [REDACTED] was returned, and in July Lyric was returned. During the children's placement the reunification plan for the mother was very similar to the one that had been implemented when the children initially came into care in April of 2010. The plan included but was not limited to: establishing a visitation plan for the mother and siblings; the mother locating adequate housing; the mother maintaining involvement [REDACTED] and submitting to drug testing. Again the mother was receptive to the plan and generally adhered to it. She was able to obtain suitable housing and once the home was established arrangements were made for children to begin extended visits, then overnights. [REDACTED]

Following the children's return the assigned worker monitored the home consistently and maintained contact with other providers extending services to the family. However, the mother continued to have difficulty in keeping her house in order. The caseworker monitored the children's physical condition and personal hygiene through personal observation and collateral contacts with other service providers. The caseworker also provided concrete assistance by helping the mother remove and dispose of trash. In September of 2012 the mother's housing situation became more complicated when her mother's home burned down. Because of this crisis the mother allowed her mother to move in with her; along with an adult sister, the sister's boyfriend and their child, who had been residing with the grandmother. This resulted in overcrowding and additional stressors. The caseworker's focus at that point was finding alternative housing for the family members who had moved into the home because of the fire. In October of 2012 the mother gave birth to her fifth child. The child was healthy at birth and was discharged to the mother following his uncomplicated delivery. The case dictation reflects frequent visits to the home to ensure housing conditions were satisfactory, the children had adequate food, were attending school, and the new baby was receiving medical care. The caseworker also continued to emphasize to the mother the importance of having members of the extended family move into their own housing.

Circumstances of Child Near/ Fatality and Related Case Activity:

On December 7, 2012 Lyric was sleeping in a bunk bed (lower) with one of her brothers. She woke up fussy at about 8:00 AM, the mother comforted her and told her that her (maternal) grandmother, who had taken her two older brothers to the school bus stop would be back soon. The mother then went to take care of her two month old infant. When the grandmother returned she went into the room Lyric was sleeping in, gave her a sippy cup with Kool Aid in it, and laid down next to her. Both Lyric and the grandmother dozed off. About 20 to 30 minutes later the grandmother woke up and observed Lyric lying on her stomach beside her; she was limp, unresponsive, and not breathing. Reportedly the grandmother attempted rescue breaths and CPR in an attempt to revive the child. EMS was contacted and responded quickly. EMS continued attempts to resuscitate while the child was transported to a local hospital; after examination in the Emergency Room there, a decision was made to transfer Lyric to [REDACTED]. Upon arrival at [REDACTED] the child was admitted and sent to the [REDACTED]

██████████. The child was given a CT scan and no head trauma was found. The child was also given a skeletal survey which did not reveal any evidence of trauma. The child had no finding of ██████████ and no outward signs of trauma. However, given the fact that there was no clear explanation for the child's critical condition the hospital reported the case as a suspicious event to ██████████ which registered it as a near fatality.

Subsequent to her admission, Lyric's clinical status continued to worsen. ██████████

██████████. After ██████████ and discussions with her family, Lyric was removed from life supports and died on 12/12/2012.

On 01/03/2013, following its investigation of the ██████████ report related to the fatality of Lyric, which included consultations with local law enforcement and a review of available medical records, Lawrence County CYS submitted a ██████████ with a status of ██████████. This determination was made because there was no evidence to establish that the child's fatality was the result ██████████.

Current Case Status:

Law enforcement did not pursue criminal charges against either the mother or grandmother; case was closed with ██████████ being ruled out as a cause of Lyric's death. As of this writing, the medical examiner report and exact cause of death has not been issued however the medical records from the time of death listed the cause as "respiratory and cardiovascular failure (lack of air) of unknown etiology."

The family remains active with Lawrence County CYS which continues to provide in home services, as well as monitoring services of other agencies providing assistance to the family. Those service providers include Cray Youth Services, ██████████, and ██████████. The mother and her children are together in the family home. The agency focus includes involving the mother in ██████████ related to Lyric's death and to facilitating efforts to move mother's sister, her boyfriend, their child and the grandmother out of the family home. The mother has continued to struggle ██████████. She is involved with ██████████. The mother's sister and her family moved to their own housing in March; the grandmother left the mother's home shortly after their departure.

The case record reflects that the mother continues to struggle with maintaining the home. The caseworker has made extensive efforts to assist her but her housekeeping skills remain marginal. The older children are presenting behavioral issues in the school setting and the mother appears to be inconsistent in following through with her ██████████ she remains ██████████ and since her mother's departure has had difficulty in meeting day to day needs of her children, such as getting them ready for school on time.

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

Not applicable, the county agency completed an investigation related to the [REDACTED] report and filed a status determination of [REDACTED] within 30 days of the receipt of the report.

Department Review of County Internal Report:

Not applicable.

Department of Public Welfare Findings:

- County Strengths:
The assigned caseworker has made extensive efforts to assist this family in dealing with socio-economic variables, [REDACTED] that have impacted the mother's ability to ensure the safety and well being of her children. He has visited the family frequently, extended concrete services, and attempted to engage other service providers that are working with the family.
- County Weaknesses:
There has been a demonstrated inability to effectively engage members of the nuclear and extended family in working together to resolve issues of enmeshment as described in the above summary. Similarly, despite the workers best efforts to engage other providers in coordinating efforts to assist the family, service planning appears to be fragmented.
- Statutory and Regulatory Areas of Non-Compliance:
There were no statutory or regulatory findings of non-compliance identified during the review.

Department of Public Welfare Recommendations:

- The Department recommends the county agency engage the family in a Family Group Decision Making conference.
- The Department recommends that this case be scheduled for a Critical Case Review involving all providers extending services to the family; the Department will attend the review upon notification.