pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Kaleb Reiber

Date of Birth: 01/26/2015
Date of Death: 05/03/2015
Date of Report to ChildLine: 05/03/2015
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Allegheny County Office of Children, Youth and Families

REPORT FINALIZED ON:
December 8, 2015

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:

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, 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.

Act 33 of 2008 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 (ACOCYF) has convened a review team in accordance with Act 33 of 2008 related to this report. The county held a pre-review meeting on 06/01/2015, and the review team was convened on 07/20/2015.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Kaleb Reiber	Victim Child	01/26/2015
[redacted]	Sibling	[redacted]2009
[redacted]	Sibling	[redacted]2011
[redacted]	Biological Mother	[redacted]1984
[redacted]	Biological Father	[redacted]1979
*[redacted]	Paternal Grandmother	[redacted]1956
*[redacted]	Paternal Grandfather	[redacted]1946
*[redacted]	Maternal Grandmother	[redacted]1967

* 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 Department of Human Services, Western Region Office of Children, Youth and Families (DHS) obtained and reviewed all current and past records pertaining to the [redacted] family. DHS staff participated in the pre-review team meeting on 06/01/15, in which ACOCYF intake, on-going and quality assurance staff, as well as the review team facilitator attended. DHS staff also attended the review team meeting held on 07/20/15, in which there was representation from ACOCYF intake and family services departments, as well as medical professionals, law enforcement, Deputy District Attorney and Allegheny County Department of Human Services. Information regarding the incident as well as historical information was presented. An interview with the supervisor was conducted on 09/25/2015 to obtain an update related to the case activity.

Children and Youth Involvement prior to Incident:
The initial referral to ACOCYF was made on 11/12/2011 when it was reported that the sibling born on 11/11/2011 tested positive for [redacted] at birth. The mother tested positive for [redacted] and marijuana. The mother reported a history of IV [redacted] ACOCYF intake caseworker completed an on-site assessment. No safety issues were reported and the case was screened out.

A second referral was made on 11/22/2013 [redacted] The two siblings, ages 2 and 4, were at home with father. The mother had advised the reporting source that she was concerned about the children being in the father's care, but would not provide specific details about her concerns. The reporting source overheard the mother talking to the father on the phone telling him to pick the siblings up from the maternal grandmother. The reporting source confronted the mother about the comment she made and the mother admitted she made the statement about the father because she was "mad at him." The reporting source was concerned about the two young siblings being exposed to domestic violence.

ACOCYF went to the hospital to speak to the mother [redacted] The mother reported that the father hit her and she fell. Both parents were to receive a summons for domestic abuse. The case was accepted for services on 01/20/2014. The case was referred to the family services unit at which time the case was reassessed and determined there was not a need for ongoing services and closed on 02/06/2014.

The third referral was made on 3/14/2014 at which time the mother showed up at a local hospital for a sick visit regarding the youngest sibling, who was 2 years old at the time. The 2 year old reported to the ER with vomiting, diarrhea and a mild fever. The reporting source believed that the mother was under the influence of a substance upon arrival to the hospital. The mother was reported as "lethargic" and barely able to be aroused to fill out the forms. The reporting source spoke to the maternal grandmother who reported that the mother was [redacted] and had been "sleepy and lethargic" at home as well. The maternal grandmother raised concerns that the mother had medications lying around the house and that the mother was "clueless", and not caring for the children properly.

An on-call intake worker was assigned to respond to the allegations. The caseworker contacted the paternal grandparents who reported numerous concerns related to the parents. Both parents were reported to have extensive substance abuse histories. At the time of the report, the father was incarcerated for Identity Theft, False Report to Incriminate Another, False Identification to Law Enforcement and Driving While Operating Vehicle with Suspended or Revoked License. It was

reported that there had been general neglect of the children, and a high volume of traffic in and out of the home. The paternal grandparents reported that they frequently cared for the children and provided financial support. The oldest sibling was being cared for by the maternal grandmother during this time, per a private arrangement with the mother and the grandmother.

[redacted] The case was accepted for services on 03/14/2014. [redacted]

The 5 year old [redacted]. At times, her behavior negatively impacted the younger sibling's behaviors, resulting in physically aggressive acts between the siblings. Due to these behaviors, the grandparents became overwhelmed with the children. In support, a paternal aunt assisted with the caregiving. The siblings had regular contact with the maternal grandmother and other extended family members. The mother was testing negative for illegal substances [redacted]

[redacted] The victim child was born on 01/26/2015 and tested positive for [redacted] The child was [redacted] the care of the mother and a [redacted] as [redacted] the mother was consistently testing negative for substances. The siblings began visitation with the mother, at first under supervision and progressing to unsupervised.

The father was released from jail on 12/23/2014 [redacted] At this point he was living in the home with the mother and the victim child. On 03/23/15, the agency held a conferencing and teaming meeting to discuss the father's [redacted] and develop a safety plan for the mother to supervise his contact with the children. The mother was in compliance with her goals so it was determined that she would supervise the father's contact with all of the children.

On 04/04/15 [redacted] A report was never made to the agency nor did the father report the incident to the caseworker. The father also had criminal charges pressed as a result of this [redacted] The victim child was seen medically on 04/26/15 and was gaining weight and on target; immunizations were up-to-date and no concerns were noted.

On 4/28/15, the agency child and family advocate went to the family home and completed the Family Assessment Screening Tool (FAST) assessment and Ages & Stages Questionnaires® (ASQ) developmental screening. [redacted]

Circumstances of Child Fatality and Related Case Activity:

On 05/03/15, at 7:59am the agency received a call from the [redacted] reporting that they had responded to a [redacted] call as the mother was reportedly outside screaming that her baby was not breathing. The police and EMS immediately responded to the parent's home and identified the victim child to be deceased. He was transported by ambulance to a local hospital and it was reported that there were no visible signs of trauma and the cause of death was unknown. The victim child was pronounced dead by a hospital physician at 8:04am. [redacted] reported concerns as there appeared to be bruising to the victim child's face and head as well as other marks to the arms. The conditions of the home were described as "deplorable"; clothing everywhere in the home, cigarette containers and food all over the kitchen and there were concerns regarding the hygiene of the children. [redacted] reported that the parents appeared to be "high." [redacted] the parents and transported them to the hospital for toxicology screens. The 6 year old sibling of the victim child [redacted] She was visiting with her parents for the weekend. The 3 year old had been placed back into the legal custody of her parents. The paternal grandparents responded to the home to pick up the siblings.

[redacted] further reported that they had received a [redacted] call the day before (05/02/2015) due to the parents being observed by a passerby to be under the influence in a public location with the children. [redacted] and allowed the parents to go home with the children. A report was not made to ACOCYF regarding this incident.

Later that day, the County Police Detective reported that the mother was arrested on 3 counts of felony charges of Endangering the Welfare of Children due to the conditions of the home [redacted] The detective reported that the father had also been arrested on 3 counts of felony charges of Endangering the Welfare of Children. He was handcuffed to the hospital bed and taken to county jail upon release from the hospital. The Detective also reported that the mother had filled a prescription on 05/01/15 for 90 1mg. Klonopin to be taken 3 times a day, and there were only 12 pills in the bottle. The parents had admitted to chewing the pills.

The family services assigned caseworker and supervisor responded to the paternal grandparent's home to assure the safety of the siblings. The siblings appeared to be dirty and their clothing was unkempt and dirty. The paternal grandfather reported that when he dropped the 6 year old off at the parents' house on Friday (05/01/15) for her weekend visit, everything was fine. The caseworker and supervisor explained [redacted] The maternal grandmother, the paternal great-grandmother and two paternal aunts and uncles were at the paternal grandparents' home and involved in this discussion. [redacted] The families lived in close proximity to each other and would ensure regular and on-going contact with the siblings.

The children were transported to the Children's Hospital of Pittsburgh's Child Advocacy Center for a physical exam. A forensic interview with the 6 year old was completed [redacted]. There were no concerns noted in the siblings' physical exams. The 6 year old reported that she was visiting her parents and siblings for the weekend. She reported that her mother told her to give the victim child his bottle and to put him in the mother's bed. She reported that all three children slept in her mother's bed. She stated she woke up and the victim child was lying next to her and that his nose was bleeding, he had blood from his eye and he was cold. She stated she held him but he did not wake up so she took him to their mother and described her mother crying and her father attempting to perform CPR on the victim child. It was determined from the 911 call that the father was performing adult CPR on the victim child.

ACOCYF staff initiated the ChildLine report and the case was registered as a fatality. The autopsy report is dated 05/04/2015 and indicated the cause of death to be sudden unexplained infant death. The manner of death could not be determined. The skeletal survey post mortem revealed no fractures. It was noted that there was [redacted]

On 05/04/2015 the family service caseworker contacted the [redacted] and spoke to the responding officer. The officer reported that there had been two calls regarding the family on 05/02/2015. The first was at 7 am when they received a call regarding a disturbance between the mother, father and the downstairs neighbor who was blaming the parents for breaking a window and stealing items from the home. The second call was at 1:12pm to complete a welfare check at an ice cream shop as the adults were reportedly acting strangely. The paramedics also responded to the second call. When the officers arrived, the parents did not have slurred speech; the mother reportedly was a little unsteady but stated that she had a foot injury. The mother admitted to [redacted] use and the parents were searched. They were not in possession of drugs or paraphernalia and there was no indication of drug use at that time. The responding officers discussed making a report to ACOCYF the following Monday; and then they responded to the home the next day and found the victim child deceased.

On 05/27/2015, the intake caseworker and family services supervisor visited the [redacted] Jail to interview the parents. The mother declined to be interviewed regarding the victim child's death. The father consented to the interview and discussed the events from 05/01/20151-05/03/2015. He reported that on 05/01/2015, the 6 year old came to the home for a visit. The family had dinner and went for ice cream. The victim child slept in the pack-n-play and the siblings moved into the parents' bed at some point. On 05/02/2105 the family went to the park and the victim child was reportedly fussy; the mother was allegedly holding him on her lap and the victim child rolled down her legs, but per the father did not appear to be injured and was acting normal. Between 9-10pm, the siblings were put to bed and all three children were in the bed together. Between 10-11pm, the mother took the victim child out of bed and placed him in the pack-n-play. He stated that he awoke around 7am when the mother and the 6 year old reported that something was wrong with the victim child. He reported that the 6 year old found the victim child unresponsive in the bed, and blamed the 6 year old for getting the victim child out of the pack-n-play and putting him back into the bed. He denied that either he or the mother was under the influence, but acknowledged that the mother had [redacted]. He reported that sometimes the mother nods off when she takes the pills together, but denied that she did so this weekend. He acknowledged that the police stopped the family on their way home from getting ice-cream earlier in the weekend, but denied that either he or the mother was intoxicated.

On 06/17/2015 [redacted] There is a jury trial scheduled for 10/14/2015 regarding the Endangering the Welfare charges against both parents. The initial bail was set at $100,000 for the father and $75,000 for the mother; this has been reduced to $49,500 for each. The parents remain incarcerated.

The siblings are doing well in their kinship placements. The paternal and maternal grandparents have a close relationship and encourage the siblings to visit several

days a week, and every other weekend they alternate overnight visits. They attended camp together over the summer. [redacted]

[redacted]

The agency has not received the results of the toxicology screens for the parents blood draws taken at the hospital on 05/03/2015.

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:
Allegheny County Department of Human Services' Fatality Team convened on July 20, 2015.

Strengths in compliance with statutes, regulations and services to children and families:

- ACOCYF intake immediately responded to the child abuse report, ensured the immediate safety of the surviving children, and conducted a timely investigation.
- The family had received in-home services through ACOCYF for several months prior to the child fatality to support reunification of the surviving siblings. [redacted]

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

- No deficiencies were noted by the Child Fatality Review Team.

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 recommended that ACOCYF develop and institute a protocol for safe reunification practices.
- The Review Team recommended review of active systems and communication among those systems as a core component of assessment, planning and tracking in advance of permanency planning, including reunification.
    - [redacted]

      Two other systems were aware of the incident and were planning accordingly; however, ACOCYF was not informed of the incident or the

plans to address his needs. A review of the active systems' involvement and collaboration may have impacted ACOCYF's assessment of the family's functioning and planning for the safety of the children.

- The Review Team recommended review of the Safety Assessment and Management Protocol and appropriate follow-up with staff.
    - In early 2015, father had not yet made sufficient progress in his ACOCYF family goal plan to warrant unsupervised contact with the children, and as a result, his visits were to be supervised by mother. While this plan was endorsed by the agency, mother noted it created tension between her and father. (The family had a reported history of intimate partner violence as well.) The Review Team discussed the appropriateness of a parent's assuming supervisory responsibility for the other parent's contact with their children and recommended further assessment of any risk factors associated with such planning prior to the decision for parents to assume visitation supervision.
- The Review Team recommended that ACOCYF photograph home environments at regular intervals, particularly in cases where either a child resides in the family home or reunification is planned. In this case, there were varying opinions as to the physical condition of the home at the time of the child fatality.
- The Review Team recommended that ACOCYF practice require the filing of [redacted]

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

- The Review Team recommended that Allegheny County Department of Human Services track compliance with recommended improvements through administrative review and internal quality assurance processed.

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 that assessment and planning practices include routine review of all Allegheny County Department of Human Services and public databases, including ClientView, to determine other program office and service involvement with family members to enhance system collaborative performance and mitigate risk to children.
- Allegheny County Department of Human Services is engaged in planning with adult criminal justice system to enhance data sharing capacity between the child welfare and criminal justice systems, including electronic alerts from

criminal justice to child welfare, associated with potential safety threats and/or risk factors for child protection, and non-monetary conditions of bond or bail for crimes that impact children.

[redacted]

Department Review of County Internal Report:
DHS received Allegheny County Department of Human Services Act 33 Report on 09/23/2015. The Department finds the internal report to be an accurate reflection of the Act 33 meeting. The report content and findings are representative of what was discussed during the meeting on July 20, 2015.

Department of Human Services Findings:
County Strengths:

- DHS would like to acknowledge the fact that the family services caseworker and supervisor responded to the crisis and worked collaboratively with the assigned intake caseworker to assure the safety of the siblings, to interview the parents, to offer provided support to the extended family members, to assure that the siblings were seen medically and that the 6 year old had a forensic interview. Notable collaboration occurred between the agency and involved law enforcement.
- The family services caseworker and supervisor allowed the extended family to be a part of the decision making process [redacted] The agency followed up [redacted].
- The agency assisted the family in identifying a [redacted]
- The family services caseworker continues to routinely visit and makes efforts to engage with the parents at the county jail.

County Weaknesses:

- The Department agrees with the weaknesses and recommendations made by the Fatality Review Team.

Statutory and Regulatory Areas of Non-Compliance by the County Agency:
There are no statutory or regulatory areas of non-compliance noted.

Department of Human Services Recommendations:

- The Department is concerned with the recommendation related to [redacted] The concern is that this practice needs to include the completion of a safety assessment and a risk assessment upon the birth of the child. [redacted]

A full assessment of the situation needs to be completed, which would include a discussion with an [redacted].

- The Department recommends that the agency work to enhance its collaborative efforts with other Human Service agencies, as well as other state and county programs that are providing services to the same families. [redacted] importance of communicating information when it is related to the safety and well-being of children.
- The Department recommends educating local police departments regarding their immediate role in the efforts to assure safety and well-being of children. Despite the fact that the local police department responded to concerns regarding these parents twice in one day regarding a domestic dispute and concerns that the parents were intoxicated, a report was not made to the ACOCYF or ChildLine. These referrals involved concerns regarding the safety and well-being of three children under the age of 6, which would require immediate reporting in order for ACOCYF to have responded to assure the safety of the children.
- The Department recommends further education for Probation and Parole Officers regarding their role in the efforts to assure safety and well-being of children. Probation and Parole Officers should be aware if children reside in the homes of their clients and enlist ongoing collaboration with the child welfare agency involved with the families.