



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:

Christopher Jackson

Date of Birth: 01/25/2011
Date of Death: 04/02/2011

FAMILY KNOWN TO:
Allegheny County Children, Youth and Families

Date of Oral Report: 04/01/2011
Date Report Finalized: 02/16/2013

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. 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. Allegheny 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>
<i>Household Members at time of death:</i>		
Christopher Jackson	Child Victim	01/25/2011
[REDACTED]	Babysitter/Godfather	[REDACTED] 1980
[REDACTED]	Babysitter/Godmother	[REDACTED] 1985
[REDACTED]	Victim's Sister	[REDACTED] /2008
[REDACTED]	Mother	[REDACTED] /1990
[REDACTED]	Father	[REDACTED] /1988
[REDACTED]	Paternal Grandmother	[REDACTED] 1978
[REDACTED]	[REDACTED] Husband	[REDACTED] 1976

The living arrangements for this family are as follows:

- The mother resided with the maternal grandfather.
- The father is incarcerated for previous crimes.
- The Godparents have their own residence, but cared for the victim child in their home at the mother's request. Because mother worked Monday through Friday, she felt it easier for everyone if the victim child stayed at the Godparents' residence through the week, with mother picking him up on Fridays.
- The victim child's sister resided with the paternal grandmother and has done so since birth. This arrangement was made because mother was attempting to "get herself together."
- Mother stays with paternal grandmother on the weekends so she can visit with her daughter.

Notification of Child (Near) Fatality:

Allegheny County Children, Youth and Families (ACCYF) were alerted to the death of this child via a fax from [REDACTED] at 10:58 PM on April 1, 2011. According to the fax, the child was brought to the Emergency Department at [REDACTED] by the child's mother and Godparent. While in triage, the child was immediately noted to have [REDACTED], so the child was taken to [REDACTED]. At this time, the child's respiratory rate was 10 and he had no pulse. As a result, CPR was initiated. Upon initial exam, the child had no overt signs of trauma.

The mother told the hospital staff that the child was being cared for by his Godparents. Around 2:00 PM on April 1, 2011 they noticed that he was not breathing, so they reportedly performed CPR on the child until he was breathing again. After doing this, they noted that the child remained unresponsive and "not right" so they placed the victim child in their car, drove to pick up the mother at her place of employment, then took the child to the hospital. They arrived at the hospital at approximately 5:35 PM. The hospital was concerned about the delay in seeking medical care for the child and whether this delay led to the fatality of the child.

The Western Region Office of Children, Youth and Families (WROCYF) were notified of this child fatality on April 1, 2011 at 11:30 PM by [REDACTED]. According to the information provided by [REDACTED], picking up the mother at her work and taking the child to the hospital would have taken over one hour rather than contacting 911 and using an ambulance, which would have significantly decreased the amount of time it took for the child to receive medical treatment. The treating physician noted that "there is a worrisome delay in seeking treatment that led to the near death at 5:30 PM to the subsequent death at 9:00 PM."

ACCYF had no history with this child and family. The Penn Hills Police Department was notified of the fatality via a CY-104 submitted by the county.

Summary of DPW Child (Near) Fatality Review Activities:

As part of the review of this child fatality, the Department reviewed the agency record and participated in the internal review meeting held on June 2, 2011. During this internal review meeting, a representative from the [REDACTED] [REDACTED] was present to report their findings.

The case record contained the agency's documentation as well as the hospital [REDACTED] notes and the initial police report.

Summary of Services to Family:

At the time of the incident, the children and family were not receiving services from any providers.

Children and Youth Involvement prior to Incident:

Allegheny County CYF had no prior reports on either the victim child or his sister. However, the agency confirmed that both the mother and father were involved with CYF as children. [REDACTED]

[REDACTED]. The record also showed that the father and his brother were both [REDACTED] their paternal great grandmother in 1999.

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

As noted previously, the victim child had been in the care of his Godparents on April 1, 2011 when he stopped breathing. The Godparents reported that they performed CPR on the child. The child began to breathe again, but he was described as still being unresponsive. As a result, the Godparents decided to take him to the Emergency Department at [REDACTED]. Although they felt the need to seek medical treatment for the child, the Godparents did not use emergency services to transport the child instead they drove to the mother's work to pick her up on the way to the hospital. This would have added at least an extra hour onto the time it would have taken for the child to be seen had the child been taken via ambulance.

The agency assigned the report to one caseworker, but initially used multiple workers to assist in the early stages. In the morning of April 2, 2011, an ACCYF caseworker made contact with the hospital [REDACTED] and local police department to obtain more information regarding the situation.

The [REDACTED] reported that the mother did not initially offer a lot of information regarding the family situation. The mother stated that the child's sister was in the care of the paternal grandmother, who owns a daycare where the mother is employed. The [REDACTED] described her interaction with the mother as "weird" because the mother was on her cell phone at the hospital just after her son passed away and was making plans to go out with friends.

In the morning of April 2, 2011, two caseworkers conducted a home visit to the mother's residence, where the mother was interviewed as well as the other household members. In addition to the household members, the paternal grandmother was called by a caseworker and asked to bring the child's sister and be present at the mother's home to be interviewed. The paternal grandmother and child's sister were present upon the caseworkers' arrival.

The paternal grandmother stated that she has been caring for the victim child's sister since her birth, with mother staying at her home on weekends. When asked about the circumstances surrounding the child's death, paternal grandmother stated that he had been congested at that time. She also said that the victim child had also stopped breathing "momentarily" while in her care, but

he would always breathe again on his own. On the day of the child's death, the child was with his Godparents, who are also his paternal great-aunt and uncle. When the Godparents decided to take him to the hospital and get the mother on the way, they contacted the paternal grandmother so she could go to the daycare and relieve mother, as mother was working.

The paternal grandmother stated that the child's sister was born premature and weighed only two pounds, three ounces. The grandmother said that the sister was often congested "like her brother" and would also stop breathing "all the time" but then breathes on her own. The grandmother reported that both children were seen regularly by a pediatrician, who she identified. As per the paternal grandmother's report, the maternal grandmother just had the victim child to the pediatrician the week prior. The pediatrician allegedly said that the child was healthy but congested and with a [REDACTED]

While the paternal grandmother was being interviewed, another caseworker was interviewing the mother in a separate room. The mother confirmed the living arrangement for her daughter because she was trying to "get herself together." She also stated she worked at the paternal grandmother's daycare for one year; which was her first job.

As far as the victim child's living arrangements, the mother said that he stayed with his Godparents from Monday through Friday because it was easier. The mother said that the maternal grandmother took the child to a doctor's appointment on Friday, March 25, 2011 at approximately 1:30 PM and cared for him until Saturday, March 26th, when she returned him to mother's care at the maternal grandfather's residence. Later that same day, the Godmother came to pick the victim child up and he remained in her care until being taken to the hospital on April 1, 2011.

The mother said she became aware that something was wrong with the child when the Godmother called her and told her he had stopped breathing and they performed CPR on him to get him breathing again. The mother said that the Godmother told her that although the child was breathing again, he "spit up" and "bubbles" came out of his mouth, so they both agreed that the child should be taken to the hospital. Mother reported that it was at her request that the Godparents picked her up because she wanted to go to the hospital with them. When asked by the caseworker if she considered having the Godparents call 911, the mother became what was described as "slightly irritated." She stated that the Godparents were her only ride to the hospital and she had no way to get there if they didn't pick her up. The caseworker suggested that 911 could have been called for transport and the Godparents could have still picked her up, but the mother answered by saying she wanted to go with them.

The caseworkers obtained demographic information of the caretakers and household members to help ensure the safety of the child's sister, since she was

being cared for by paternal grandmother. During her interview, the paternal grandmother reported that her husband was currently residing at a half-way house, but stayed at her residence on the weekends for home passes. While present, the paternal grandmother's husband arrived at the home for his home pass and reluctantly agreed to submit to a background check. Upon running clearances on these persons, it was discovered that paternal grandmother's husband has a "lengthy" arrest record including "several" Title 18 offenses, none of which were against children. As a result of this history, the agency decided to place the remaining child [REDACTED], at least temporarily, until the grandmother's home could be explored further.

In the evening of April 2, 2011, the agency obtained [REDACTED]
[REDACTED].

On April 4, 2011 an agency caseworker contacted the child's father in the county jail to advise him of the sibling's placement [REDACTED]. The child's father stated that while he may be the sister's father, paternity had yet to be established. He was attempting to get this accomplished through family court. He stated that if he is found to be the father of the child's sister, he would like to be her caregiver.

On April 5, 2011 the assigned caseworker contacted the [REDACTED] [REDACTED] to obtain any results or information regarding the child's death. While a full report would not be available anywhere from 6 to 15 weeks, the caseworker was advised that there were no signs of trauma, although other screens had been completed and were still pending.

Also on April 5, 2011 the assigned caseworker had a videoconference with the child's father to discuss the circumstances surrounding the death of his child and to learn what information, if any, he could provide.

The father reported that he was not advised of his son's death until the mother visited him at the jail. He also said she wasn't able to provide him with a lot of information, as she was too upset. The father claimed he was unaware of his son's breathing problems, but knew that the sister had breathing problems. He stated that the sister "grew out of it," meaning her breathing problems. The caseworker reviewed the allegations with the father, which he was unaware of.

The caseworker advised the child's father that the sister was remaining [REDACTED] [REDACTED]. He stated that he and the child's mother lived with his mother after her birth, but they later moved out to get their own apartment, leaving the sister to be cared for by the paternal grandmother. He also described this decision as he and the mother "getting themselves together," which was clarified further to mean get jobs, furnish the home, and continue to "grow up." They did maintain contact through visits.

The child's father stated that his court date was May 24, 2011 and he anticipated being released at that time.

On April 8, 2011 the agency conducted a home visit with the Godparents, who were also the [REDACTED], and the mother. The Godmother was interviewed first and provided the following history related to what transpired on April 1, 2011.

According to the Godmother, she and the Godfather usually awaken between 7:00 and 7:30 AM to get their children ready for school. On that day, the Godmother had not been feeling well, so she remained sleeping and the Godfather cared for the child in the morning. She reportedly got up around noon, changed the child's diaper, and gave him a bottle. Part of the Godparents' daily routine with the child was for all three of them to take a nap usually between noon and 2:00 PM. She stated that she woke from her nap around 2:15 PM. When she checked on the child, who was in a car seat, the Godmother noticed that he wasn't breathing. According to [REDACTED] report, the child's eyes were half closed, but his coloring appeared "normal." The Godmother said that at this point, she screamed for her fiancé and she "was in a panic." The Godmother handed the child to the Godfather and went into the hallway to attempt to call the mother at her work, but left a message to call back immediately and to tell her they were calling an ambulance for the child. The Godmother said that her fiancé told her that the child was breathing again but he had "spit up all over the place." The baby's spit up was described as not his "normal" spit up, but was "foamy" and may have had some mucous in it, not milk. The mother called the Godparents back and was "hysterical," telling them to "bring him." When the Godmother told the mother that the baby was breathing again but needed to go to the hospital, the mother told them to pick her up because she wanted to go to the hospital too. The Godparents didn't know any of the child's medical information, so they picked up the mother and dropped her off at the hospital with the child. The Godparents went to pay the mother's cell phone bill so she would be able to use it from the hospital. They were awaiting a phone call back from the mother to let them know when to pick her up.

The mother began staying with the Godparents just after she had given birth to the child because she had [REDACTED] needed to stay in a place without steps. While staying there, the mother asked them to help throughout the week with the child. The Godmother had no concerns for the child's health, other than having a lot of mucous, but she claimed the pediatrician told her that this was common and could be treated with a nasal syringe. The child was described as a very active baby that interacted well with them. The Godmother did comment, however, that the child "wasn't the happiest baby" and that he would stiffen his legs, cry, and scream even after being fed, burped, changed, and being held.

The Godmother reported that during the weekend of March 24 – 26, 2011, the maternal grandmother had the child for a few days and took him to the pediatrician. She said that she told the mother to talk to the doctor again about the child's mucous. The Godmother also revealed that they were putting about one teaspoon of cereal in the child's formula because he was so small. The only medical issue the Godmother commented on was that the child showed some "light" symptoms of [REDACTED] upon his return on March 26th, but the doctor gave a prescription that the child received four times per day. The child either slept with them in their bed or in his car seat.

The paternal grandmother was also present for this visit and provided some background information on the father and other family history. The paternal grandmother again stressed her interest in being a caretaker for the child's sister, who was still [REDACTED] at that time.

Following the Godmother's interview, the caseworker met with the mother to obtain more information regarding the child. As per mother, the child was two weeks premature, weighing 5 pounds, 14 ounces at birth and being 18" long. The mother claimed having regular pre-natal care, missing no appointments. She also said that after being born, the child had three appointments with the pediatrician, with the maternal grandmother taking him to his most recent one.

The Godfather interviewed last. He began by saying that he woke up around 7:00 AM to help get his two school-age children ready and off to school. He said that the child is usually up at this time too, so he gave him a bottle, changed his diaper and clothes, and cleaned the child up. Normally, the child would go back to sleep, however, this day the child was "dozing" and stayed up until about noon. The child and Godparents usually take a nap before their children return from school. On that day, they woke up around 2:00 PM and the Godmother checked on the child. He said that she told him that the child wasn't breathing and handed the child to him, so he performed CPR on the child. The caseworker inquired if the Godfather was certified, to which he replied he was not, but had "done so on other individuals." The Godfather said that the child burped up "bubbles and foam" and "came back," then "pooped his pants." He felt the child needed to be taken to the hospital via ambulance and was going to call an ambulance. However, the Godmother was on the phone with the mother, who asked them to pick her up so she could go with them. He reported it took them approximately one hour to pick up the mother and he was unsure what time it was when they dropped the mother and child off at the hospital. They left to go get more minutes for her cell phone, as she had exhausted all of them.

The Godfather reported that the child had been in their care for approximately one month, but had never stopped breathing before during that time period. He felt the child did have a lot of mucous and was congested and "nasally," but they used a nasal syringe to clear out mucous. The child did not have a crib, but slept in the car seat or in bed with them. They had intentions of purchasing a crib for

the child. The mother reportedly visited with the child on weekends and other times when she was able.

On April 18, 2011 the caseworker spoke with a physician at the treating hospital, who described the child as "for all intents and purposes, dead" upon being removed from the car seat at the hospital. He had [REDACTED] which are described as "end-life breaths" and had no palpable pulses, but was still warm, so the hospital staff worked on the child for approximately 60 minutes. After 60 minutes, they obtained a pulse, so the child was transferred to the [REDACTED] but had [REDACTED] while there. They again worked on the child for 70 minutes, but were unable to resuscitate. Without knowing the exact cause of death, the doctor stated it would be very hard to answer whether the delay in treatment contributed to the child's death.

While the agency was making regular contact with the mother, sibling child, and paternal grandmother on an ongoing basis, those contacts were specific to the sibling child's living situation and follow-up services for the mother, father, grandparents, etc.

On May 23, 2011, the assigned caseworker contacted the [REDACTED] to inquire about a full report. Although the full report was still incomplete at that time, the [REDACTED] was able to state that there were no signs of trauma to the child. However, the results for the microscopic slides and toxicology reports have not been finalized. The slides would have shown if the child had any form of disease and toxicology would reveal any substances in the child's system. While the child did have [REDACTED], they were attributed to the administering of CPR.

As a result of the [REDACTED] statement that there was no trauma to the child and the treating physician's inability to state the delay in treatment contributed to the child's death, the [REDACTED] report was [REDACTED] on May 26, 2011.

Current Case Status:

This family's case is currently closed. [REDACTED] the case was closed with the agency on July 26, 2011. The mother has informal visitation.

No criminal charges were filed for any of the caregivers.

The agency made the following recommendations and/or referrals to help support the family:

- A referral for [REDACTED] to aid the mother
- Developmental assessment for sibling child recommended
- Referral for [REDACTED]

- Interactional evaluations with the mother, sibling child, and paternal grandmother
- The paternal grandmother assisted the mother in completing an application for [REDACTED]

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

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

- Strengths:
 - No statutory or regulatory compliance issues
 - Immediate response to the report
 - Thorough investigation conducted
 - Immediate safety plan put in place for sibling
- Deficiencies:
 - No deficiencies were noted.
- Recommendations for Change at the Local Level:
Reduction of the likelihood of future child fatalities and near fatalities directly related to [REDACTED]
 - Continue to promote safe sleep, including access to safe sleep furniture
- Recommendations for Change at the State Level:
 - Request that the PA American Academy of Pediatrics alert pediatricians to the need for prompt responses to medical record requests in [REDACTED] cases

Department Review of County Internal Report:

The Western Region Office of Children, Youth and Families received the entire record for this report on March 12, 2012. Included in the record was the county's final report.

The Western Region is in agreement with the findings.

Department of Public Welfare Findings:

County Strengths:

- Prompt response by the county to the investigation
- Good collateral contacts to gather information

- Using multiple workers in the first couple of days of the investigation (team approach)
- Multiple contacts with the father in jail
 - Kept him apprised of placement of non-victim child
- Good documentation
- Safety Assessments done on biological children of Godparents
- Pro-active safety plan due to paternal grandmother's husband
- Good referrals for family
- Achieved permanency for the sibling child

County Weaknesses:

- No safety assessments on the sibling of the child who suffered the fatality was included; one should have been provided for justifying the removal that took place on 04/02/2012

Statutory and Regulatory Areas of Non-Compliance:

There were no areas of non-compliance noted.

Department of Public Welfare Recommendations:

Although safety assessments were included for the children of the Godparents; these two children were not part of the victim child's family. There wasn't one included in the file for the sibling of the child who was subject of the fatality report, who was placed into agency custody for approximately two weeks. It is unclear why assessments of the Godparent's children were included and the sibling's was not. The agency could be more consistent in their practice of including/not including such documentation. If these assessments were intentionally included, the siblings should have been as well.