pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Raven Aster-Biscardi

Date of Birth: 01/12/2016
Date of Death: 03/25/2016
Date of Report to Child Line: 03/25/2016
CWIS Referral ID: [redacted]

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

Bucks County Children & Youth

REPORT FINALIZED ON:
09/13/2016

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.

Bucks County Children and Youth convened a review team in accordance with the Child Protective Services Law related to this report. Bucks County had convened the ACT 33 Review Team Meeting on April 20, 2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Raven Aster-Biscardi	Victim Child	01/12/2016
[redacted]	Mother	[redacted]1993
*[redacted]	Father	[redacted]1993
*[redacted]	Paternal Grandmother	[redacted]1968
*[redacted]	Father of [redacted]	[redacted]1977
*[redacted]	Paternal Aunt	[redacted]2011

*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 Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current investigation case notes conducted by Bucks County investigator, as well as her Supervisor. Follow-up interviews were also conducted with the Assistant Director of Bucks County Children and Youth Services. Moreover, SERO did an extensive [redacted] review on the information obtained [redacted] pertaining to victim child's death.

Children and Youth Involvement prior to Incident:

Bucks County has had the following referrals pertaining to this family prior to the passing of the victim child on March 25, 2016:

On 01/30/2016, the county received a [redacted] and a [redacted] referral relating to the victim child's father hitting

her and the father and his mother (paternal grandmother) selling as well as smoking methamphetamines in the home. During this assessment, the victim child's mother, father and paternal grandmother were all drug tested. Further, father and paternal grandmother both tested positive for methamphetamines and amphetamines. The mother's test was negative and the victim child remained in the care of the mother. Mother had moved out of the home. There was a safety plan put into place for the remaining child in the home which places the victim child's father as the caretaker (responsible person) of the child in the home and that child's mother (paternal grandmother) agreed to leave the premises. [redacted]

On 02/12/2016, the county received a [redacted] referral pertaining to the victim child's mother trying to break into the father's home by climbing through a window with the victim child in her arms. It was reported that the ladder fell and the victim child was injured. The investigation revealed that the mother and victim child did not climb through a window nor did they fall off a ladder. This report was rendered as unfounded.

On 02/20/2016, the county received a [redacted] referral pertaining to the mother taking the victim child to [redacted], a known high drug area to buy drugs. The report also read that the mother is high all the time and is currently home using the drugs with a friend. During the assessment, the mother was drug tested and the results were negative (02/24/16) and there was no observable drug paraphernalia or odor in the home and the victim child appeared clean and appropriate. This report was rendered as invalid. However, the case was transferred to the [redacted] Division on 02/22/2016.

On 02/28/2016, the county received a supplemental [redacted] referral pertaining to the mother going to the father's work place demanding money to buy drugs and the victim child was with her. The report also stated that the mother went to the father's home at 7:00 AM, also with the victim child, looking for money. The referral source stated that mother is actively using drugs; however, mother denied the allegations. This report was invalid.

On 03/23/2016, an unknown reporter stated that there are drugs being used in the mother's home and the home is not clean. Also, it's unknown if anything happened to the victim child. The county made an unannounced visit on that same date but no one was at the residence. However, it was noted that the worker left a voicemail message for mother.

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

On 03/25/2016, the county received a telephone call from [redacted] stating that the victim child had passed away. It's reported that the police were called to [redacted] home, by [redacted], and found the victim child non-responsive. Moreover, it was reported by [redacted] that [redacted] had been napping with the victim child and when she woke up the victim child was non-responsive. Further, [redacted] may have rolled on the child. The county worker

met with [redacted] on 03/26/2016 where [redacted] denied drug usage and she refused to take a drug test. The Bucks County Coroner's Office report indicates the cause of death to be sudden death of a co-sleeping infant. The County filed an [redacted] report on 05/18/2016. The county cited that after repeated admonitions concerning co-sleeping [redacted] slept with the child; consequently, as a result, the child suffocated and died. There is no further agency involvement with this family due to there being no other children in the home and the county closed the case.

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

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

The collaboration between Bucks County Children & Youth and the Police was a strength. The county reported that they had several staff involved in contacting and visiting the family discussing safe sleep protocols with [redacted]. Also, the county interaction with the family was reported as a strength due to their ability to assist [redacted] in moving forward with [redacted]

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

No deficiencies noted.

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

Continue education as it relates to Safe Sleeping by the county's staff including "Red Flags": issues of young parents missing children's pediatric appointments as well as issues surrounding insurance coverage transitions and/or coordination.

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

No recommendations at this time.

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

No recommendations at this time.

Department Review of County Internal Report:

The Department has no concerns with the county internal report.

Department of Human Services Findings:

County Strengths:

The collaboration between Bucks County Children & Youth and the Police was a strength. Also the county ability to give a swab drug test on the spot is a strength as it saves time by getting the results back much quicker.

County Weaknesses:

No weaknesses noted.

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

No areas of non-compliance at this time.

Department of Human Services Recommendations:

The Department recommends that after multiple referrals on a family (GPS and/or CPS) that are being monitored by the county, there should be an administrative review determining the next steps for the family up to and including the removal of the child.