



*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**

**Tamera Haight**

**BORN: February 25, 2010**  
**DIED: March 19, 2010**

**FAMILY KNOWN TO:**  
McKean County Children and Youth Services

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. McKean 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>
Tamera Haight	Child	2/25/2010
██████████	Sibling	██████████/2008
██████████	Mother	██████████/1985
██████████	Father	██████████1986

**Other Household Members:**

**Gunn Family:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	Father	██████████/1988
██████████	Mother	██████████/1991
██████████	Child	██████████/2009

**Household Visitor:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
██████████	██████████ Uncle	██████████/1972

**Notification of Child Fatality:**

On March 19, 2010 the Bradford City Police received a 911 call for an unresponsive infant. Upon arriving at the home the police were met by ██████████, the father of the unresponsive infant and the father of the other family sharing the home with the ██████████ family. Tamera Haight, the unresponsive infant was deceased; she was found to be fully clothed, soaking wet, and was cold to the touch. Her mother, ██████████, was found in the bathroom, she was also deceased. She was lying on her back on the floor with her head toward the door. Her pajama bottoms were around her ankles and her underwear was around her mid-thigh. Her upper body, head and hair were wet. She was bluish in color, cold to the touch and showed no signs of respiration. There was blood coming from the corner of her mouth. McKean County Children and Youth Services was notified and the agency took ██████████ of the sister and the other child living in the home. Both girls were ██████████.

### Summary of DPW Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past records pertaining to the [REDACTED] family. The case file for the other family living with the [REDACTED] family also was reviewed. On March 30, 2010 Regional Program Representatives [REDACTED] and [REDACTED] interviewed workers from the service providers that worked with the [REDACTED] family. These interviews included [REDACTED] and [REDACTED] from the [REDACTED] program, [REDACTED] a [REDACTED] from the Smethport Family Center, [REDACTED] from [REDACTED]. Also interviewed were the following McKean County Children and Youth Services Staff: [REDACTED], the agency director; [REDACTED], assistant director; [REDACTED], supervisor; and [REDACTED], caseworker. The Western Region participated in the agency's MDT meeting by telephone conference on April 20, 2010. The Autopsy reports for [REDACTED] and Tamera Haight were made available to the Western Region in September of 2010. The Western Region has maintained regular contact with McKean County Children and Youth Services concerning this case.

### Children and Youth Involvement prior to Incident:

The [REDACTED] family was initially referred to McKean County Children and Youth Services in November of 2008. A report was received on 11/25/08 alleging overcrowding in the home. A second report was received on 11/26/2008 with allegations that the father had digitally penetrated [REDACTED], age 8 months. The investigating caseworker went to the family residence at [REDACTED] on 11/26/08. The caseworker interviewed the father, the mother, and the tenants of the home. No disclosure was made about sexual allegations. Upon arrival, due to the sexual abuse allegations, the caseworker asked to check the subject child's diaper area. When the caseworker removed the diaper on the child, the child started screaming and crying. After the diaper was removed the caseworker observed the child having [REDACTED] or [REDACTED] of some sort. The father had stated that the child has had a [REDACTED] for about a month and is on [REDACTED]. The caseworker told the parents that they need to take the child to the Pediatrician immediately. The caseworker made a phone call to [REDACTED] to update the nurse on the current situation and condition of the child. The caseworker received a phone call later that afternoon from [REDACTED] stating that the child's [REDACTED]" and the child was being transferred to the Bradford Regional Medical Center Emergency Room. The caseworker received another phone call later that evening from Bradford Medical Center Emergency Room stating that there was no sign of sexual abuse; however the child had a [REDACTED] was prescribed to the parents for the child.

The caseworker completed a Safety Assessment which identified the safety threats as being the [REDACTED]; the father's known history of child maltreatment; related to his conviction of statutory rape [REDACTED]. The father was not taking his [REDACTED] for a [REDACTED] and the home the family was staying at was too crowded. The safety plan that was established with the parents included the

following steps: the parents will set up a Doctor's appointment for the child by the end of the day; the parents will assure that the child's basic/medical needs are met; the parents will use the [REDACTED] as prescribed; the parents will no longer reside at [REDACTED] and needed to return to their residence on [REDACTED] in Bradford, Pa. Furthermore, since the father was on Adult Probation for Statutory Rape the safety plan included that the father would not be unsupervised with any child under the age of eighteen and he would not bathe, dress or change the child's diaper at anytime. The safety plan also included a statement that the family will cooperate with Children and Youth Services. Both parents, the caseworker, and the supervisor signed the safety plan on 11/26/2008.

Six additional home visits were made during the investigation; the focus of these home visits was the child's diaper rash that was not improving. These visits were conducted primarily with the mother and the child. Even when the father was in the home he did not actively participate. The caseworker observed the diaper rash at each home visit. On several of these home visits when the caseworker arrived at the home the parents were sleeping and the child appeared to have been awake in her crib. The caseworker instructed the parents that the child should not be left alone in the crib. The caseworker would review with the mother the child's feeding schedule and the types of foods the child was eating. The caseworker also reviewed with the mother how often she was changing the child's diaper and how the mother was changing the diaper. During the home visits there were no concerns noted about the housekeeping. There was food in the house and the utilities were on at each visit. The safety plan was proactively revised after each home visit. The revisions pertained to the diaper changing and the supervision of the child. The revised safety plans were signed by the mother, caseworker and supervisor.

The caseworker had several conversations with the father's Adult Probation officer concerning the terms of his probation. The Probation officer confirmed that the father was on Adult Probation due to being charged and convicted of Statutory Rape. According to the Probation Officer, the father had completed the terms of his probation and he was finishing up the time of the probation. However one of the conditions of his probation was that he was not to be a sole caretaker for the child because the stipulation of the probation was that he could not be alone with any child under the age of 18.

The caseworker spoke with the worker from [REDACTED]. This service was working with the family prior to the referral to Children and Youth Services. The worker stated that mom has been very compliant with services. She had never seen the child alone with the father. [REDACTED] only works with families until the child reaches the age of one. The worker told the caseworker that she had referred the family to [REDACTED].

The caseworker had several conversations with [REDACTED] and on one occasion spoke to the Doctor. He told the caseworker that the rash should clear up within 2-3 weeks if the diaper is being changed and cleaned properly. [REDACTED] are hard to clear up. The child's medical records were obtained by the agency.

The agency made referrals to the [REDACTED] and the [REDACTED] Program for the family. The caseworker made sure that these services were in place. The [REDACTED] worker reported to the caseworker that when she was in the home the mother was

attentive to the child. She referred the family to an intensive worker for basic parenting skills with parents. The [REDACTED] reported to the worker that the child's diaper rash was better. She also reported that the mother has [REDACTED]. The [REDACTED] instructed the mother to take the child to the Doctor since her hands had been purple/red throughout the investigation. There were concerns about her circulation. The Doctor told the agency that this was a one time occurrence with no apparent cause. There was [REDACTED] and it did not appear to be caused by [REDACTED]. The [REDACTED] worker reported that the child's diaper rash had improved and both parents were participating in the program. [REDACTED] reported that the mother was keeping the appointments for the child.

The agency completed a Risk Assessment in 1/22/09. The overall severity was rated as Moderate. The rationale for this rating was the severity of the child's diaper rash and the fact that the diaper rash was ongoing. The overall Risk was also rated as Moderate. The rationale for this rating was the parent's lack of parenting knowledge and the possible lack of supervision of the child by keeping her in the crib. During the investigation the agency learned that along with the father's criminal conviction of statutory rape he was refusing [REDACTED].

The case was accepted for service on 1/22/09 and transferred for ongoing services on 1/26/2009. Case Planning and Risk Assessments were completed as required by regulation. The parents participated in the development of the Family Service Plan and signed it.

- For each of the months that the case was open the caseworker made at least two home visits a month. There were several months when weekly home visits were made to the family.
- The child's [REDACTED] was the focus of the case. The caseworker noted that at each home visit the child's diaper rash was checked. In February the family was provided [REDACTED] for the month. The caseworker and nurse educator instructed the parents on changing the child's diaper and cleaning the child. They would review with the parents what the child was eating. The caseworker confirmed that the child's medical appointments were being kept. The diaper rash seemed to be doing okay when in May of 2009 the diaper rash took a turn for the worse. During a home visit the caseworker observed that the child's diaper rash appeared to have worsened and she instructed the parents to take the child to the Emergency Room after the 5/15/2010 home visit which the parents did. The caseworker instructed the parents to keep a log on dates and times of diaper changes. When the [REDACTED] still did not improve the caseworker accompanied the mother and child to the doctor's appointment. They saw the nurse practitioner. The instructions from that appointment were that the parents were to use the [REDACTED] three times a day and use Vaseline in between. The parents were to quit using wipes and use washcloths and place the child in warm water to help loosen stools before wiping her. The nurse practitioner would not make a statement for [REDACTED]. The caseworker ensured that the family had clean wash cloths and Vaseline. By the beginning of June 2009 the child's [REDACTED] had cleared up. The caseworker continued to monitor the diaper rash and although she noted on a couple of her visits that the child's bottom appeared red the rash did not return. Until case closure the caseworker reviewed with the parents how to care for the diaper rash.

- Housing was another critical issue with the family. The family moved frequently and often times lived with another family. Housing conditions and cleanliness were dependent on who the family was living with. When the family was living in their own home cleanliness was not an issue. There were times when the family was living with another CYC client. It was identified that one of the reasons that contributed to the family's housing instability was the fact that the father had a temper and would sooner or later have a conflict with another adult in the home. There were several times that the mother and child [REDACTED]. The family would then reunite. By July of 2009 they had obtained their own housing.
- The caseworker spoke with the father's adult probation officer to clarify the terms of the father's probation. The Probation Officer said that the father could help care for the child as long as he was supervised. He told the worker that the father's conviction stemmed from an incident that occurred between the father, when he was eighteen, and a girl who was thirteen. The father's probation would end on July 30, 2009. As of that date there would be no longer any laws that the father would have to follow. He would not be required to register as a Megan's Law Offender. The father completed the terms of his probation and was released from probation by the time the case was closed.
- While working with the family the agency was aware that the mother was intellectually limited. The mother also suffered from a [REDACTED] for which she was [REDACTED]. Even though the father had a history of [REDACTED], he was refusing [REDACTED].
- The parents were able to work with the [REDACTED]. At times their relationship with [REDACTED] was strained.

The case was closed in August of 2009 based on the parents completion of agreed upon goals of the Family Service Plan.

On 10/2/09 the agency's after hours on-call received a report alleging that: the family was living in a house with out electricity; the child had diaper rash and the parents do not know how to get rid of it; there are other household members identified as living in the home; the father has a history of being violent. The caseworker made an unannounced home visit on 10/3/09 and there was no one home. The family was living at the same address as when the case was closed. On 10/4/09 the Caseworker made a home visit to the home with a Bradford City Police Officer. When the caseworker arrived at the home there was another family there. However, the family told her that the other family was just visiting. The caseworker found that half the house had electricity. There was food in the residence. The house was clean and fully furnished. The caseworker checked the child for a diaper rash. Her bottom was red but there wasn't a rash. The mother told the caseworker how she was treating it with A & D ointment. The parents told the caseworker that they were still working with [REDACTED]. Caseworker completed a safety assessment that concluded that there were no safety threats. A risk assessment was completed and the case was closed.

On 1/7/10 the agency received an anonymous report that a child was locked behind a gate in her room while parents sleep; the child never gets bathed and is always dirty; there was barely any food in the home; the family had moved and they were sharing the house with another family; the house is messy and they have been living there for 2-3 weeks and have not finished unpacking; the father and the father of the other family call the child "retard and stupid" and say they are going to "break her fingers if she touches things she shouldn't"; the father in the other family prompts his own daughter to tell the child to "shut the fuck up". The reporting source knew that the agency had been in the home in the past because of the child's severe diaper rash. Later that day the caseworker made a home visit to the home. When she arrived at the home the child and the other family's daughter were in their bedroom with the gate up and they were playing. The other family's daughter had gone to the hospital for diaper rash a while ago and she was on medication for the rash. The child also had diaper rash and they had been using A&D ointment. The mother said that the child's next doctor appointment was 2/26/10. She signed a consent form for the agency to obtain medical records. There were no services working with the family because the father did not want anyone in the house. Both the mother and father were each [REDACTED]

[REDACTED] They reported that the rent was \$475.00 per month and they had to pay for the gas and electric, which needed to be paid.

On 1/13/10 the caseworker made a follow up home visit with the family. There was plenty of food in the home. The child's bottom was still a little red and they were still using A&D ointment. The mother informed the worker that she was pregnant and reported that she would find out on 1/25/10 the date for her [REDACTED]

On 2/10/10 the agency received another anonymous report that the house was disgusting, specifying that: the dishes look like that they have not been done in a week, there was garbage all over the floor, the dining room was the only clean room, and the children of both families are only fed Lunchables and junk food. The reporting source did not believe that there was real food in the house. The children in both families are yelled at for no reason and their hands are smacked for no reason. Reporting source said that both fathers in the household are violent and that father has [REDACTED]. Later that day the caseworker and a Bradford City Police Officer went to the home. The fathers were home with their daughters. Both girls were sleeping. The mothers had gone to the store to get dish soap and garbage bags. The caseworker met with family along with police. There were dirty dishes and garbage that had overflowed in the floor including coffee grounds and egg shells. There was food in the home. The parents said that Lunchables are snacks for the children before dinner. The father said that he did not want services in the home. The caseworker told them to clean up the house and she would be back the next day. The caseworker returned to the home the next day and the mother gave the caseworker a tour of the house. The house had been cleaned up. The mother reported that she is [REDACTED] every Monday. She agreed to work with [REDACTED]. The mother also told the caseworker that the father suffered from [REDACTED]

On 2/21/10 the agency received a report that the child came out of the parent's bedroom with a gun. The gun was taken from her. The reporting source stated that the father was violent and that he had made comments that he was going to do something to CYS workers if they ever came back to the residence. On 2/22/10 the caseworker and the Bradford City Police went to the residence. Initially the father refused to let worker search the house, eventually he did. House

was searched and no gun was found. The record does not reflect if the father was questioned about the allegation that the child had carried a gun.

On 3/16/10 at 4:10 PM the agency received another report on the family; this report was that the father is very violent towards mother and the children. The father was being very abusive towards mother and children. The father is violent and was over heard on the phone saying that he would "kill the mother and the kids." The agency did not respond to this report.

**Circumstances of Child Fatality and Related Case Activity:**

On 3/19/10 The [REDACTED] city Police received a report of an unresponsive infant. The [REDACTED] responded to the call for an ambulance at [REDACTED]. Upon arriving at the house there was no one standing outside of the home. When the Police entered the home the father pointed for him to go to the back of the house where he found three week old Tamera lying on a dryer. The child was blue, the police chief checked for vital signs. The infant appeared to be dead for some time. Another individual in the home told the Police that there was someone else dead in there, pointing to the bath room. Upon entering the bathroom the police found the mother's body. The police took protective custody of the sister and an unrelated one year old, who was the child of a family sharing the home with Tamera's parents. It should be noted that the agency had not received a referral from Bradford Medical Center or anyone else notifying them of Tamera's birth.

The agency [REDACTED]. The other family's child was placed with her maternal grandmother after her clearances were obtained and an assessment was completed on her home. The agency began working with the father based on preliminary findings of the police investigation that he was not responsible for his child's or his wife's deaths.

The father did not provide the agency with any kinship options for his surviving daughter and she remained in foster care. The agency established a weekly visitation plan for the father and the child. The father told the agency that he would have to find housing for himself and his daughter. He did not want to return to his prior residence because he did not want the child to be looking for her mother. Initially the visits between the father and the child were supervised due to the father's [REDACTED]. Other than wanting his daughter returned to his care the father was unsure of what his future plans were going to be.

On 3/26/10 during an interview with the police a household member [REDACTED] told the police that he was angry with the mother. He pushed the mother into the bathtub while she was holding the infant. He then turned on the water and began filling the tub with water holding her head under water until she stopped resisting. The perpetrator was arrested and charged with two counts of criminal homicide for the deaths of the mother and the child. He was incarcerated in the County Jail and denied bail. The [REDACTED] was residing in the home at the time of the murders. He was

living there at the invitation of his niece, who was a member of a family that the [REDACTED] were sharing the home with.

Although the Police stated that the father was not a person of interest in the case, they had concerns that other household members were withholding information. The caseworker interviewed the father with the police on 4/22/10. The mother and the father of the other family living in the home at the time of Tamera's death were interviewed by the caseworker and the police on 4/27/10.

[REDACTED], at the direction of his attorney, refused the opportunity to be interviewed by the caseworker. [REDACTED] is the uncle of the mother of the other family who had been living in the home. [REDACTED] had returned to Bradford to live with his father. Mr. [REDACTED] father had kicked him out of the house so he moved in with his niece. According to the father [REDACTED] was accused of inappropriately touching his girlfriend's daughter in Ohio and that was why he returned to Pennsylvania. This has not been verified. According to the other adults in the home [REDACTED] was not seen as contributing to the household and there was conflict about him staying there. McKean County CYS does not have a record of him in their system. According to the other adult household members everyone in the household was asleep when Tamera and her mother were killed. On the date of the incident; [REDACTED] woke the father up first and said that the mother had a [REDACTED]

The [REDACTED] report was completed on 5/14/2010 and [REDACTED] was assigned to the report.

### **Current Case Status:**

After the mother's death the agency set up weekly visitation for the father and his surviving daughter at the [REDACTED]. The caseworker observed positive and appropriate interaction between the father and his daughter. The father was encouraged to seek [REDACTED] through the [REDACTED]. After the police cleared the father of involvement in the mother's and Tamera's deaths, the agency [REDACTED]. The child was returned to the father's care. The case remains open with the agency. The father is receiving services from [REDACTED]. The father continues with services for himself through the [REDACTED]. The child is receiving her medical care through [REDACTED]. The father receives [REDACTED] at the [REDACTED]. The agency does not have results yet. Stable housing continues to be a problem. At one point after the mother and sister's death the father moved another family into the house. He is scheduled to obtain housing in the community where the grandfather lives. The father has formed a good working relationship with the current caseworker he will ask for her help when he needs it. An FSP was completed with the father and he signed the document. Risk Assessments and Safety Assessments have been completed as required.

The current status of the criminal case against [REDACTED] is that the Court has not made a determination if he is mentally competent to stand trial.

**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 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. McKean County convened a Multiple Disciplinary Team meeting on this matter in accordance with Act 33 of 2008 related to this report. The meeting was held on April 20, 2010. At the time of the meeting the criminal investigation was still ongoing and this limited the information that could be presented and discussed at the meeting.

Strengths:

- The team included representatives from the Police, District Attorney's office, the County Coroner, McKean County Children and Youth Service workers, the Region participated by phone.
- The team discussed the agency's involvement with the family since January of 2010. The circumstances of the child death were discussed. Since the police investigation was ongoing there wasn't information shared by law enforcement about the status of the criminal investigation.

Deficiencies:

- The team did not include representatives from service providers that had worked with the family. These services included the [REDACTED] and Adult Probation. The team did not include representatives from medical, educational, mental health, drug and alcohol, and domestic violence fields. These viewpoints were not heard.
- The family's history with the agency from 2008-2009 was not discussed in the meeting.

Recommendations for Change at the Local Level:

- The agency must expand the MDT team to include all the required representatives.
- The agency must ensure that the report issued accurately reflects their past involvement.
- The agency should have discussions with the D.A. regarding holding the MDT meeting within thirty days of the incident. The D.A. can certify that the release of information will compromise the criminal investigation.

Recommendations for Change at the State Level:

- Criminal Investigations are not held to the same time frames as the Departmental time frames. Time frames set by the Department could result in critical case information not being available for the report.

### **Department Review of County Internal Report:**

Since the Police investigation was ongoing when the MDT meeting was held, the follow-up report included limited information about the criminal investigation. The focus of the report was the current status of the case as of 4/20/2010. The report did not include all of the agency's history with the family; it only briefly discussed the referrals since January of 2010. The history from 2008 and 2009 was not included. The report states that the agency was involved with the family because of domestic violence and home conditions. A review of the case record and the interviews conducted by the Department with provider service representatives indicate that even though domestic violence was suspected it was never confirmed. Case documentation does support the statement that the parent's relationship was strained. The report does not state that the reasons for the case being accepted for service and opened in 2008 and 2009 was because of the sister's diaper rash and the instability of the parent's housing. The family had a history of moving frequently and doubling up with other families in a house. When questioned; the mother denied that the father was abusive to her. Home conditions were not an issue during the agency's first involvement with the family. This allegation was part of the most recent referrals.

### **Department of Public Welfare Findings:**

#### County Strengths:

- The Department found no problems with the agency's involvement with the family in 2008 and 2009. During this involvement with the family the caseworkers made at least two home visits to the family per month. There was contact between the agency and the service providers. The services that were offered to the family were appropriate. The agency worked with the family to resolve the issues of the sister's diaper rash by ensuring that the family had the tools to deal with it. Risk Assessments, Safety Assessments and the Family Service Plan were completed as required.
- The agency made home visits to the family home and saw all household members for the referrals that were received in October 2009, January 2010, and February 2010.

#### County Weaknesses:

- The agency's responses to referrals received on the family in January and February 2010 were problematic. There are problems with how the intake investigations were conducted and the documentation of those investigations.
- The first issue was that the case file and the supervisor's log do not coincide with one another. According to the case file there were referrals made to the agency on 1/7/10, 2/10/10 & 2/21/10. The agency responded to each referral within 24 hours and there is a contact sheet for each home visit. There were follow up visits made to the family on 1/13/10, 2/11/10 and 2/22/10. The Safety Assessment

forms and the Contact Sheets that were originally given to the Department were incomplete and had blanks on them. The Contact Forms had the Risk and protective Capacities section of the form completed and signed by the parents, caseworker and supervisor and the rest of the form was completed at a later date. During the Departmental visit to the agency on 3/30/10, The Department was given completed Safety Assessment forms and Contact Sheets. It appears that the agency was responding to each referral as a new referral but the investigations were not completed. There were gaps in contacts with the family. There are no documented contacts with the family between 1/13/10 to 2/10/10 and again between 2/17/10 and 3/16/10. Even though the mother signed a release of information on 1/7/10 for her 2 year old's medical records there is no case documentation that they were requested. It also appears that the agency found out on 1/30/2010 that the mother was pregnant. Even though the mother told the agency who her doctor there is no documentation that the agency asked the mother to sign a release of information form for her records. The mother told the caseworker that she would be having a [REDACTED]. There was no documentation in the file that the caseworker asked the family about the child care arrangements for the sister when the mother delivered. There was no documentation in the file that the caseworker had discussions with the parents about their preparations for the new baby.

- The In-Home Safety Assessment form completed after the mother's and child's murders on 3/19/10 appears to be skewed to make the father appear in a more negative manner since as of yet no one had been arrested for the murder. The accuracy of this form is questionable. These are the concerns: The Safety Assessment repeatedly states that the father has a history of Domestic Violence with the Mother when the children were present. The case file and the interviews with the provider agencies do not support this statement. There was suspicion that domestic violence was occurring but when asked the mother denied it. Secondly, the form states that the father has history of threatening agency staff. There are statements in the file that during referrals to the agency the father made statements that he did not want CYS in the home. However, there is no case documentation of an actual threat to a caseworker. Thirdly, the form states that the father has a history of [REDACTED]. There is no case documentation to support these statements at the time of the case review. Safety Threat Point 1 states that the father was not consistent with following through with treatment for the sister's severe diaper rash which resulted in long term pain to the child. This statement contradicts the case documentation, and Safety Threat point 14 which states that the mother was the primary care giver to the child initially referred to the agency, not the father. Further more, Safety Threat point 7 states that the father provided minimal care to that child. In addition to the case documentation, the interviews with the provider agencies confirmed that due to the terms of his probation the father provided minimal care to the child. Safety Threat Point 4 states there was a history of [REDACTED] to the child by father; the report was unfounded due to lack of evidence at the time of the report. According to the case file Bradford Medical Center found that the child had a severe diaper rash and there was no evidence [REDACTED]. This report occurred in 11/08, this

statement should not have been included on the form. Safety Threat Point 8 states that there is evidence to suggest that the child's special needs are not being met. Child exhibits developmental delays with her speech. Case documentation does not support this statement. Point 8 also states that there is a history of missed medical appointments for the child. Case file and medical records do not support this statement.

- It should be noted that during the annual review of McKean County Children and Youth Services on April 27, 28, 29, 2010 reviewing Safety Assessments was a priority of the regional office review team. The problems identified in this child death review, pertaining to safety assessment, were not systemic in the cases reviewed.
- The supervisor's log has ten day reviews from 1/7/10 to 2/17/10. 1/17/10 Supervisor review states that the caseworker was to make referral to Parents as Teachers. Then there is a notation that the referral was made on 2/1/10. On 2/7/10 PAT went to do the intake and the parents were hostile. On 2/17/10 PAT wants CYC in the home when they are working with the parents. There is no documentation in the case file to support these notations.
- On 2/17/10 the Supervisor log states plan to open the family for services. This is the last documented Supervisor review. There is no case documentation that case was opened. At the time of the initial review of the case file there was not a completed Risk Assessment form in the file. Also there was not a notification letter in the file to parents on status of their case with the agency.

#### **Statutory and Regulatory Areas of Non-Compliance:**

Please see the Licensing Inspection form for the case citations.

#### **Department of Public Welfare Recommendations:**

- The agency needs to expand the Child Death Review Team to comply with Act 33 of 2008. During the Child Death Review Team meeting the agency's entire involvement with the family should be presented. The team should include caseworkers and supervisors who had prior involvement with the family, as well as representatives from community services and providers who worked with the family in the past.
- Both the regulatory and practice issue concerns about this case are related to the Intake Investigations that occurred in 2010. The Department acknowledges that there are multiple demands on an intake caseworker's time. However, it appeared through a review of the case file that a global assessment was not being conducted with this family. The case documentation showed a hurried and cursory approach to each allegation. The follow-up from the initial home visit on each referral was minimal and there did not appear to be an attempt to pull all the pieces together to form a complete assessment. The paperwork was incomplete and appeared to be inaccurate. The caseworker was not following the direction that was documented in the Supervisory Reviews and it did not appear that the supervisor was following up with the caseworker on what was to be done with the case. The

agency will need to make a determination as to need for additional training for the caseworker and supervisor.

- The agency needs to establish policies to ensure that at the time of a case transfer and closure of a case at the end of an intake assessment that the case file contains all the required medical, educational, and mental health records of the family.
- The agency needs to establish policies that written reports will be obtained from provider agencies and included in the case file.

**Conclusion:**

The Department has documented the positive impact of services to this family upon initial referral in 2008 as well as the shortcomings of the agency's recent involvement with the family. The agency recognizes that its responses to referrals received in January and February were not satisfactory. The agency has also identified the issue of families sharing living space as a contributing factor in this child's death. Often times the families do not know the backgrounds of the people that they are living with; this is tragically what occurred with this family. The agency is attempting to find potential solutions to this poverty related problem by making it a focal point of the NGA process.