

Department of Public Welfare
Office of Children Youth and Families
Western Region

Child Near Death Review

Child: [REDACTED]

DOB: 06/22/1991

Report Date: January 11, 2010
Report Finalized: February 4, 2010

Child was known to Allegheny County Juvenile Probation

This report is confidential under the provisions of the Child Protective Services Law and cannot be released further.
32 PA. C.S. Section 6340

Unauthorized release is prohibited under penalty of law .23 PA. C.S. Section 6349 (b)

I. Circumstances of the Child's Near Fatality:

██████████ was arrested and admitted to Shuman Juvenile Detention Center in the early morning hours of May 22, 2009 as a result of multiple charges, including ██████████. Upon admission to Shuman Center, a Health and Safety Assessment was completed and ██████████ reported that he had a ██████████ and he was currently taking medication. ██████████ was referred to the psychiatrist, who met with ██████████ this same day. ██████████ disclosed no past suicide attempts, nor did he indicate any current thoughts of self-harm. ██████████ and ██████████ aunt brought ██████████ medication to Shuman Center in the afternoon of May 22, 2009 and Shuman staff began administering the medication at the next possible dosage. It is unknown if ██████████ had been taking his medication on a regular basis. While at Shuman Center, ██████████ was assigned to Unit H.

On May 24, 2009 ██████████ and three other residents remained in the unit while the other residents went to the "Canteen" for recreation. The three other residents were not permitted to attend the activity due to horseplay and thus, had to remain in the unit. At approximately 6:01 PM, a Youth Care Worker performing fifteen-minute observations discovered ██████████ in his room with a braided bedsheet tied around his neck and to the frame of his bed. ██████████ was turning blue and gasping for air. The Youth Care Worker asked two other residents to push the "Emerson" button, which requests immediate staff assistance to the unit. Available staff were very quick to respond and succeeded in removing the tourniquet from ██████████ neck. Emergency Medical Services (EMS) were requested and Pittsburgh Paramedics and the Pittsburgh Police arrived on scene at approximately 6:20 PM. EMS stabilized ██████████ and he was transported to Children's Hospital of Pittsburgh, where he was listed in critical condition. Although ██████████ injuries were serious, he suffered no permanent injuries. ██████████ remained at Children's Hospital of Pittsburgh until June 24, 2009, at which time he was discharged to ██████████. He is currently in placement at George Junior Republic.

II. Nature of Child Near Fatality Review:

The Department's review of the near fatality consisted of interviews, record reviews, and a review of video surveillance from Unit H.

Persons Interviewed:

██████████, Child
 ██████████, Probation Officer
 ██████████, Paternal Aunt
 Residents ██████████ and ██████████, from Unit H (who were in the unit at the time ██████████ was found)
 ██████████, Youth Care Worker (YCW)
 ██████████, Youth Care Worker (YCW)
 ██████████, Wing Supervisor

Records Reviewed:

██████████ Resident file (including the HSA)

Unit H Log
Medication Administration Record
Incident Reports from staff involved
5 / 15 Minute Observation Logs for 5/24/2009 (3 PM to 11 PM shift)

Video Surveillance:

Video of Unit H beginning from 7 AM until 6:31 PM on 5/24/2009

At the time of his arrest and placement at Shuman Center, [REDACTED] had been living with his paternal aunt, [REDACTED], for approximately two weeks, but remained in the custody of his father, [REDACTED]. [REDACTED] went to his aunt's to reside because he was gradually violating his father's curfew and his father was unable to manage his behaviors. [REDACTED] lived with his aunt since October of 2003 due to his parents' [REDACTED] and inability to properly meet his needs. During the time he lived with his aunt, [REDACTED] had multiple arrests and citations despite her best attempts to manage his behaviors. He was also using illegal substances, including marijuana. The youth was under the supervision of Allegheny County Juvenile Probation since September 2008. According to the Probation Officer, [REDACTED] has a history of admitting himself into [REDACTED] whenever it became apparent that he was going to be placed by Probation. While [REDACTED] lived with his aunt, his father became increasingly more stable, while [REDACTED] behaviors at his aunt's began to decline.

On March 25, 2009, [REDACTED] was again arrested for incidents involving a BB gun and included simple assault, conspiracy, and possessing an instrument of crime. The incident took place at [REDACTED] apartment. As a result, his aunt informed [REDACTED] that because of his behaviors, he was going to go back to live with his father. On that day, [REDACTED] threatened suicide so his aunt transported him to the Mt. Lebanon Paramedic station where he was transported to Western Psychiatric Institute and Clinic (WPIC) and admitted.

While at WPIC, [REDACTED] was placed on medication for [REDACTED] and a "family meeting" was held to discuss [REDACTED] discharge. During the meeting, [REDACTED] told [REDACTED] that she was no longer willing to deal with his behaviors and he could not return to her home. [REDACTED] requested to live with his mother, however, his mother informed him that he couldn't go there either. As a result, he was discharged to his father's care, although he did not want to live with his father. [REDACTED] behaviors continued to decline at his father's, so in early May, the aunt agreed to have [REDACTED] return to her care so that she could ensure he was attending school on a regular basis.

In the early morning hours of May 22, 2009, [REDACTED] was picked up after curfew by Mt. Lebanon Police and during their questioning and investigation, discovered [REDACTED] had numerous outstanding warrants. As a result, he was transported to Shuman Center. Upon admission, [REDACTED] received a health and safety assessment, during which he disclosed he was taking medication for [REDACTED], already prescribed and taking Prozac 40mg qam, Wellbutrin 150mg qam, and Adderall 40mg qam. This medication was brought to Shuman Center in the early afternoon of May 22, 2009 by his aunt and

his father. The Medication Administration Record for [REDACTED] shows the meds were dispensed properly at 8 AM on May 23, 2009.

The account outlined below is a summary of what transpired in the brief period of time prior to the discovery of [REDACTED] and is based on a review of the video surveillance recording and interviews of the two of the three residents that remained in the unit. The two Youth Care Workers on duty for the 3 – 11 PM shift, [REDACTED], were also interviewed. The details of the incident are outlined in the Licensing Inspection Summary (LIS), which is attached to this document and may be referenced.

At 5:10 PM, YCW [REDACTED] contacted the nurse for [REDACTED], as he reported that he wasn't feeling well and was granted permission by the nurse to lie down in his room. At 5:46 PM, YCW [REDACTED] was preparing the unit for an activity outside of the unit. During this time, YCW [REDACTED] observed [REDACTED] in his room. At 5:50 PM, all of the residents except [REDACTED] and three others left the unit with [REDACTED] and a "floater" YCW for an activity in the Canteen. After [REDACTED] and the other staff left with the residents, [REDACTED] and two of the other residents watched television for approximately fifteen minutes. Between 5:46 PM and 6:02 PM, [REDACTED] in his room by braiding a bedsheet, wrapping it around his neck, then anchoring it to his bedframe and pulling it taut.

When YCW [REDACTED] went to conduct a fifteen minute observation of [REDACTED] at 6:02 PM, he discovered [REDACTED] and instructed the other residents to get scissors, but none were available. While a resident was in the office, the phone rang and the resident answered and asked for help in the unit. The resident also pressed the "Emerson" button, requesting any available staff to respond to the unit. As there were no scissors to cut the sheet and the staff were having difficulty removing it from [REDACTED] neck, one of the staff members bit through the sheet with his teeth to remove it. EMS responded to the facility promptly and [REDACTED] was stabilized and transported to Children's Hospital of Pittsburgh, where he was placed in Intensive Care in critical condition. As a result of [REDACTED], [REDACTED] had to have a tracheotomy and was heavily sedated for several days following the incident.

When interviewed on June 22, 2009, [REDACTED] admitted that he told no one at Shuman Center of his [REDACTED]. [REDACTED] described in detail how he began planning the [REDACTED] in the morning of May 24th and that he tore his bedsheets into strips and braided the strips together in ten minutes and within the time between YCW [REDACTED] and YCW [REDACTED] observations. [REDACTED] claims that he tightened it two or three times before YCW [REDACTED] found him, although he stated he never lost consciousness.

III. Statutory and Regulatory Compliance:

The investigation into [REDACTED] resulted in one citation of non-compliance with 3800 Regulations. Regulation 3800.283(g) states that "Staff persons are to have visual or auditory contact with children at all times." The video surveillance revealed that at several times throughout the day, including the 7 AM to 3 PM shift, Unit

H staff members did not have auditory or visual contact with the residents. At times when the residents were in their rooms for quiet time or to clean them, staff members did not routinely check on their welfare. When [REDACTED] was permitted to lie down in his room at 5:12 PM, his door was closed. Two observations were completed at 5:22 PM and 5:46 PM, however, after [REDACTED] was able to make the braided sheet after 5:46 PM because no one had visual contact with him. The two staff members in the unit began a 5-Minute / 15-Minute Observation sheet for [REDACTED] and although checks every five minutes were logged, the video shows that they did not occur.

IV. Findings:

The Allegheny County Department of Human Services Child Fatality/Near Fatality Review Team conducted a review of [REDACTED] case on July 30, 2009. The list of attendees and meeting summary are attached to this document. As a result of their review, the team found there to be issues in the following areas that contributed to [REDACTED]:

1. Communication: This was described as communication issues between Juvenile Probation and Shuman Center, as well as communication issues within Shuman Center.
2. Alert / Emergency Response Systems: The concerns related to this area were described as the need for better education / training; the lack of appropriate staff to handle MH issues; and Shuman Center staff not having access to any tools that could have been used to cut the sheet or any mechanism for requesting assistance without leaving [REDACTED]
3. System Issues: Is the use of Shuman Center absolutely necessary for a youth, i.e., is detention warranted or is there another option that might be in the best interest of the youth?
4. Behavioral Health Needs of Youth at Shuman: The youth at Shuman have been demonstrating increasing frequency and intensity of mental health issues that Shuman may be ill equipped to address on-site.

The Department concurs with the findings made by Allegheny County's Child Fatality/Near Fatality Review team, however, found additional concerns that have an impact on the safety and security of the residents at Shuman Center.

The video surveillance footage from Unit H of [REDACTED] that was reviewed from the time he awakens until the time he is discovered by YCW [REDACTED] reveals a lack of guidance and accountability for unit staff. [REDACTED] spent nearly the entire day isolated from others, whether alone at a table where he was able to [REDACTED] or in his room where he claimed to have been not feeling well. During the times he was alone at a table in the common area and writing, [REDACTED] stated that he was crying as he wrote the [REDACTED]. [REDACTED] spent a total of two hours and six minutes sitting at a table and at no point did a Youth Care Worker engage him. [REDACTED] body language throughout the day, such as sitting near the back of the group while watching TV,

putting his head in his hands, and not really interacting with other residents should have at least resulted in contact by unit staff to check on his [REDACTED]. The non-involvement with residents coupled with the lack of training/education regarding warning signs of potential harmful situations is concerning.

These concerns were brought to the attention of Shuman Center administration and a Plan of Correction is in the process of being implemented.

V. Recommendations:

As a result of the investigation summary and part of the Licensing Inspection Summary (LIS), specific recommendations were made to Shuman Center. The Administration responded to the LIS by submitting their Plan of Correction for the citation noted, as well as the other areas of concern that were brought to their attention. The recommendations and subsequent Plan of Correction are attached to this document. The Department accepted Shuman Center's Plan of Correction and continues to monitor its implementation.