

	<p style="text-align: right;">www.C4CJ.org</p> <h2 style="text-align: center;">Children's Justice & Advocacy Report</h2> <p style="text-align: center;">To promote community responsibility so every Pennsylvania child is protected from child abuse, including sexual abuse.</p>
---	--

MAXIMIZE YOUR VOICE FOR CHILDREN. BECOME A CJAR SUBSCRIBER

Exploring the connection between the opioid epidemic and human trafficking

Death of Pennsylvania infant provides troubling picture into intersection of epidemic and trafficking

August 25th - In December 2016, the shocking details related to the dehydration and starvation death of a 5-month-old infant in Cambria County was repeatedly a headliner within local, state and national news cycles.

The 5-month-old infant girl, along with her 19-year-old mother and 27-year-old father, were all discovered dead inside their home on December 23, 2016.



The county coroner would eventually rule that the parents' deaths were accidental resulting from "acute fentanyl overdoses."¹

The infant died alone suffering from dehydration and starvation approximately four days after her parents' overdosed on fentanyl.

The coroner ruled that the infant's death was a homicide "due to the neglect of the parents."² A report from the Pennsylvania Department of Human Services (PA DHS) suggests the local county children and youth agency substantiated the infant's death as child abuse resulting from serious physical neglect.³

While these three deaths sparked discussions about the lethal rate of opioid overdoses; there is another dynamic of this infant's life book that demands further exploration – the connection between opioids and human trafficking.

In ironic twist, Cambria County seeks to connect dots between opioids and human trafficking

Recently the Cambria County Sexual Assault Response Team (SART) hosted a conference - Modern Day Slavery: Human Trafficking in Our Neighborhoods⁴

¹ <http://wjactv.com/news/local/5-month-old-babys-death-ruled-a-homicide-parents-died-of-fentanyl-overdoses>

² <http://wjactv.com/news/local/5-month-old-babys-death-ruled-a-homicide-parents-died-of-fentanyl-overdoses>

³ http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_262848.pdf

⁴ <https://www.evensi.us/modern-day-slavery-human-trafficking-in-our-neighborhoods/205061699>

SART's conference spotlighted the connector tissue between the opioid epidemic and human trafficking. SART's Coordinator was quoted in an August 8th media report ([Conference connects human trafficking to opioid epidemic](#)) underscoring, "We know that we have a huge opioid epidemic here. That really comes essentially with an increase in human trafficking. Whenever you think about the drug trade, dealers can make so much money on heroin, but when they sell that heroin that heroin is gone. The difference with humans is that they don't go away. You can use that person over, and over, and over, and over again. And they're continuously making money. The amount of money that people can make is gigantic, and they realize that."⁵

Ironically this dot connecting dialogue was occurring in the same county where that 5-month-old infant died from dehydration and starvation in December.

It is ironic because undiscussed in the media reports (likely still unknown to so many) is that the parents of the infant appear to have been under investigation by the Federal Bureau of Investigation (FBI) and local law enforcement related to sex trafficking of minors.⁶ The parents were also the subject of two reports to the county children and youth agency related to "different victims" disclosing they "were prostituted by both parents."⁷

Pennsylvania's Act 33 process creates gap in learning (generates little urgency)

These critical pieces of information about the human trafficking thread imprinted into the infant's life book are found in the PA DHS Act 33 fatality review report.

Section 6343 (c) of the Pennsylvania Child Protective Services Law (CPSL) requires that PA DHS, as part of its responsibility to investigate the "performance" of county child welfare agencies, conduct a child fatality and near fatality review and provide a written report on any child fatality or near fatality, if child abuse is suspected." PA DHS report (also known as the Act 33 report) for the Cambria County infant was finalized on June 12, 2017 and recently PA DHS posted it on its website.

Act 33 reports (local and state) too rarely are reviewed or shared with key stakeholders and rarer still do they serve as the catalyst to time-sensitive policy or practice reforms to improve child safety. Equally challenging is that the state-level review is far less inter-disciplinary than what is required at the local level jeopardizing opportunities to connect dots (in a timely fashion) toward enhanced protections for the collective community of children.

Meanwhile, a local review is also required and outlined in the CPSL's Section 6365 (d). The county agency is to convene a fatality or near fatality review (again known as an Act 33) team "when a child dies or nearly dies as a result of child abuse as to which there is an indicated report or when the county agency has not made a status determination within 30 days." Similar to the PA DHS, the local review team is to generate a report that is made available to the public, unless the district attorney denies its release citing a criminal investigation or prosecution.

The Center for Children's Justice (C4CJ) filed a Right to Know (RTK) request with Cambria County on August 7, 2017 seeking to obtain a copy of the locally prepared Act 33 fatality report – a report that is required by state law to be made available to the public. PA DHS has provided repeated guidance to county child welfare agencies stipulating access to Act 33 reports is to be granted without a formal RTK request.

⁵ http://www.tribdem.com/news/conference-connects-human-trafficking-to-opioid-epidemic/article_62261238-7bbe-11e7-9944-fb95549aa.html

⁶ http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_262848.pdf

⁷ Ibid.

The county, citing Section 902(a) (3) of the state's RTK law, invoked its right to a 30-day extension stipulating that a timely response couldn't occur "due to bona fide and specified staffing limitations."⁸ The county has until September 13th to offer its next response.

C4CJ routinely encounters significant hurdles in trying to access Act 33 reports despite the law requiring transparency.

Without the local Act 33 report, it remains unclear if the county children and youth services agency was aware of the FBI's sex trafficking investigation prior to the infant's death or if the agency learned about it only after the infant had died.

Of course, the PA DHS Act 33 fatality review report confirms that the infant's death was not the first time the county child welfare agency was triggered to intervene with the family.

Immediately before the infant was born in July 2016, the child welfare agency received two reports (one on June 20, 2016 and the other on July 14, 2016) related to "different victims" disclosing they "were prostituted by both parents."⁹ The outcome of these reports is redacted from the PA DHS Act 33 report ("Cambria County Children and Youth redacted both individuals redacted").¹⁰

The child welfare agency had received a third report on November 16, 2016 "stating that the father had overdosed a day or two previously."¹¹ The infant was four months old at the time of this report to the child welfare agency. In response to the report, the agency "met with the family on December 7, 2016" and the parents were drug screened on December 8, 2016.

According to the PA DHS Act 33 report, "the mother was negative for all substances and the father was positive for alcohol." The Act 33 report continues, "The parents appeared to be meeting the child's needs at the time and (redacted) report was still active at the time of the parents' death."¹²

The PA DHS Act 33 report doesn't address whether December 7th was the first visit to the family's home, following receipt of the November report about the father's overdose.

With the limited information in the PA DHS report, it would suggest that approximately three weeks elapsed between the time of the father's overdose and when the county child welfare agency met with and screened the parents for drug use.

Of course, the local Act 33 report may set forth more details about any response (and timing of it) by the county agency, we just don't know.

⁸ http://www.openrecords.pa.gov/Documents/RTKL/pa_righttoknowlaw.pdf

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

The brief PA DHS Act 33 report doesn't, for instance, address a planted perception (due to limited information) that there was a lag time between the county child welfare agency receiving the report of a parental overdose and when the agency met with the family and checked on the safety of the then four month old infant.

The state agency's Act 33 report doesn't flesh out the county agency's response time against PA DHS's own 2012 bulletin (3490-12-01) related to response times for General Protective Services (GPS) cases. This bulletin took effect July 1, 2012 and set forth response times ranging from immediate to ten days.¹³

The immediate response is linked to when a "present danger exists" that "meets the Safety Threshold." To meet that "safety threshold" the situation must "meet all of the following criteria:¹⁴"

- "Have potential to cause serious harm to a child;
- Be specific and observable;
- Be out-of-control;
- Affect a vulnerable child;
- And be imminent"

A response, by the child welfare agency, can be delayed for 10 calendar days if the information reported "indicates that overall risk factors rated as low exist, which may place the child in danger of future harm." The bulletin continues, "The information reported does not indicate that Present or Impending Danger exists and does not meet the safety threshold."

On its own, the PA DHS report may contribute to misinformation or a perception that the agency was delayed on checking on the safety of the infant. There are just too few details in the PA DHS Act 33 report to sufficiently illuminate the response to this infant and her family immediately before her birth and again in November and December 2016 (following the father's initial overdose).

PA DHS clearly has more information (some of which will always remain confidential). The state agency may just decide against releasing too much information, including any fuller retracing of the county agency's specific (and chronological) involvement with the family.

This dearth of detail, however, may also be a signal of the need to improve the quality (and accountability) of the Act 33 reviews undertaken by PA DHS and the resulting reports it issues.

Role of accessing information (effective investigations) to assess child safety

PA DHS' Act 33 report also invites what is a pretty consistent question when a child dies - how much information did those responding have access to about any earlier child welfare or law enforcement involvement?

Obviously, the PA DHS Act 33 report illustrates that the infant's family was already on the radar of law enforcement given the cited investigation into "sex trafficking of underage girls."

¹³ http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_005995.pdf

¹⁴ Ibid.

PA DHS doesn't, however, shed light on whether that critical piece of information was known to the child welfare agency and if so, to what degree, it factored into the decision to leave the infant in the parents' direct care after the parental overdose (and in light of earlier prostitution allegations).

Given state law about multidisciplinary investigations, it seems hard to believe that law enforcement and child welfare were not already cooperating and sharing information given the 2016 reports about "prostitution", but what seems like it would and should have been effective practice wasn't explored (or confirmed) in the PA DHS report. Also, it could be that the allegations involved adults not children.

A complication in the situation may have been the impact of any inter-state movement of the family.

There is evidence that the family had lived in New York. Still, it is unclear how long the family had been residing in Cambria County or whether the infant was born in Pennsylvania or New York.

The infant's mother and father both maintained a social media presence.¹⁵ The father had recently posted a number of gun-related online videos (e.g., the "most overrated" concealed carry weapons¹⁶ and how to clean and disassemble hi-point handguns¹⁷) within his Twitter feed.

New York court records appear to signal that the infant's father faced a weapons-related criminal charge in Suffolk County, New York. A media report indicates that he, along with two other males, "threatened to use" a "loaded .380 caliber handgun" while in a crowd.¹⁸ After responding to the incident, the media report notes that the males "fled into a nearby house" where a "56-year-old resident...tried to stop" the males from entering. Another non-media internet post cites the arrest and arraignment of a Jason Chambers ("originally was arrested under the name Jason Moore").¹⁹ An online search of the New York State Unified Court System suggests that Chambers pleaded guilty to a weapons charge and received a conditional discharge sentence (meaning no jail or probation).²⁰

After the infant's death, a media report indicated that the deceased family was discovered by an acquaintance of the parents on December 23, 2016. This person was later criminally charged related to a stolen firearm (.380 caliber) that was in the home when he discovered the deceased family.²¹ Police were looking for the firearm after they were told that the infant's father regularly had the weapon in his possession. The news report indicates that police discovered a "significant amount of ammunition in the home," but they did not recover any firearm.

¹⁵ On Twitter - @JAeDoNTSTP and @chelseacardaro and Facebook <https://www.facebook.com/chelsea.cardaro>.

¹⁶ <https://www.youtube.com/watch?v=3YcqIL-jYaw&feature=youtu.be&a>

¹⁷ <https://www.youtube.com/watch?v=D-Zse-6w4Ok&feature=youtu.be&a>

¹⁸ <http://www.newsday.com/long-island/suffolk/3-face-weapons-charges-in-north-bellport-incident-1.2242864>

¹⁹ <https://patch.com/new-york/patchogue/home-invasion-suspects-arraigned>

²⁰ https://iapps.courts.state.ny.us/webcrim_attorney/Detail?which=charge&docketNumber=el54B4I_PLUS_GCrIDKSe/2nkcw==&countyId=RGmOR4u7mFEnUqEBkD3k3Q==&docketId=w7fg7UdXt4CMJusoMpD_PLUS_Kg==&docketDseq=o6PDyKlx4BvSfbvyCgDnHw==&defendantName=Chambers,+Jason&court=Suffolk+First+District+Court&courtType=L&recordType=C&recordNum=oj2P9PWif0IFj7WTdpZKEQ==

²¹ http://www.tribdem.com/news/police-man-who-found-kernville-family-dead-also-stole-and/article_cea067b2-d6b7-11e6-8b16-83b0fda318bc.html

With regard to the infant's mother, court documents provide some clue that the family was living in Cambria County prior to the infant's birth.

In February 2016, the infant's mother pleaded guilty in Cambria County to a summary criminal offense related to retail theft.²²

The local Act 33 report might delve deeper into any other criminal justice or social services involvement, but for now the details are slim.

Disconnect between overdose and trafficking revelations and recommendations set forth for prevention

PA DHS indicates that a local Act 33 fatality review team was convened on January 18, 2017. This review meeting included input from "medical professionals, social service professionals, school district representatives, and law enforcement."²³

Until the county releases its Act 33 report, what that team discussed and recommended remains a guessing game. Even with the benefit of the local report it may still be pretty hard to understand the depth of dialogue, brainstorming and despair present in the local Act 33 meeting. It also may prove a brief document, because the county agency saw the review as less needed given the parents and the infant were all deceased.

Gaining fuller insight, at this time, is also complicated by the fact that PA DHS has not yet published any quarterly summaries related to child fatalities and near fatalities substantiated as child abuse in calendar year 2017.²⁴ These summaries are distinct (and non-identifying) from the Act 33 reports, but they often fill in details unfound (or redacted) in the Act 33 reports.

PA DHS does indicate that the county-level Act 33 team did not offer any recommendations about "changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse."

Meanwhile, the regional and state offices of PA DHS offered no recommendations in response to the infant's death.

The absence of any discussion of any prevention or intervention strategies related to human trafficking is notable.

In February 2017, C4CJ filed a RTK request with approximately 50 counties setting forth some specific request of any policies or practices the county has put in place related to infants who are born having been prenatally exposed to drugs or alcohol or where a parent/caregiver overdoses in the presence of a child.

The Administrator for the Cambria County child welfare agency responded to C4CJ's request on March 31st. The administrator noted that the agency "follows the Child Protective Services Law for both CPS investigations and

²² <https://ujportal.pacourts.us/DocketSheets/MDJReport.ashx?docketNumber=MJ-47102-NT-0000084-2016>

²³ http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_262848.pdf

²⁴ <http://www.dhs.pa.gov/publications/quarterlysummariesofchildfatalitiesnearfatalities/>

GPS assessments” and also provided “checklists utilized by caseworkers in conducting” child abuse investigations or GPS assessments.

The agency’s March response to C4CJ concluded, “Please be aware that the agency, the county, other human services entities, and the community at large is very concerned about the issues for which you are requesting information. Together we are working to address the opiate epidemic and the impact on our most vulnerable citizens.”

The agency’s response didn’t indicate if any recent policies or checklists had been put in place (or reworked) in the wake of the infant’s death.

PA DHS’ Act 33 report was silent on whether the local (or state) review undertook a discussion about the opportunity for prevention and protection when the child welfare agency responds to a report where there are young children (outside the subject of the report) or where the birth of a new baby is imminent.

For now, a five page PA DHS Act 33 report provides the only window into the county’s overall recommendations about prevention and protection children:

- That the local child welfare agency “continue their internal conversations about how they respond to parents/caregivers using heroin and to parents/caregivers who have overdosed.”²⁵
- Also that the local child welfare agency “explore what kind of information/resources they can provide for the parents/caregivers in relation to their addiction and how they can encourage them to build a network of support.”

²⁵ Ibid.