



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

ASHLEE ROUSE

Date of Birth: 05/31/2013
Date of Death: 06/06/2013
Date of Oral Report: 06/06/2013

FAMILY NOT KNOWN TO:

Blair County Children, Youth and Families

REPORT FINALIZED ON: 02/07/2014

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. 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. Blair County did not convene a review team in accordance with Act 33 of 2008 related to this report as this report was unfounded on July 2, 2013 which was within 30 days of the oral report.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Ashlee Rouse	Victim child	05/31/2013
██████████	Mother	██████████ 1990
██████████	Maternal Grandmother	Unknown
██████████	Father	██████████ 1987

*The child's father is not a member of the victim child's household. He had no contact with the child.

Notification of Child Fatality:

On June 6, 2013, Blair County Children, Youth and Families, (BCCYF), received a report from ██████████, indicating that the child had been brought to the hospital on June 6, 2013, shortly after 8:00 am by ██████████ Ambulance and was pronounced dead at 8:42 am at the hospital. It was reported by ██████████ to the agency that the child had suffered a ██████████ and that child abuse was suspected.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed the Blair County Children, Youth and Families Child Protective Service investigation file. The file was inclusive of medical reports, agency safety and risk assessment records and dictation. The CROCYF interviewed Blair County Supervisor ██████████ who conducted the agency investigation.

Children and Youth Involvement prior to Incident:

Blair County Children, Youth and Families had no involvement with the family prior to receiving the [REDACTED] Report on 06/06/2013.

Circumstances of Child Fatality and Related Case Activity:

The mother and the child, resided with the maternal grandmother in her home. There were no other children in the home. The mother and the child shared a bedroom in the home. The child's father is [REDACTED], who resides at [REDACTED]. He had no contact with the child since her birth.

[REDACTED], the PA State Police requested that Blair County Children, Youth and Families not contact or interview [REDACTED]. The PA State Police did provide to the agency the [REDACTED]. The mother stated that she and the child went into their bedroom at 7:00 pm on 06/05/2013. The child was in a "boppy seat" and remained sleeping in the "boppy seat" throughout the evening. The "boppy seat" was described as a portable child carrier/seat. The mother reported that she awoke at 8:00 am on 06/06/2013, found the child nonresponsive and called 911. The 911 Operator instructed the mother how to perform CPR until the paramedics arrived. Upon their arrival the paramedics immediately took over performing CPR and transported the child by ambulance to the [REDACTED] Hospital, [REDACTED]. The child could not be revived and was pronounced dead at 8:42 am. The child was then taken to JC Blair Memorial Hospital, [REDACTED] for an autopsy. [REDACTED], a forensic pathologist performed the autopsy on 06/06/2013. He informed BCCYF that he would not be determining a cause or manner of death for at least 30 days, at which time he will complete/release his autopsy report.

Although there were no other children in the home, the mother has a son, [REDACTED] who resides with his father, [REDACTED]. Blair County Children, Youth and Families requested a safety contact with the child and [REDACTED] on 06/06/2013 from [REDACTED] County Children and Youth Services (CCYS). CCYS conducted the safety contact and a safety plan regarding [REDACTED] contact with this child was developed. The safety plan agreed to by the mother, father, CCYS and Blair County Children, Youth, and Families provided that [REDACTED] would have no contact with the child pending [REDACTED].

On 07/02/2013 the results of the autopsy were provided to the agency and the PA State Police. [REDACTED] the forensic pathologist who performed the autopsy on 06/06/2013 ruled the child's death to be "Death by Natural Causes". The child was determined to have a viral infection which lead to Necrotizing Hepatitis which affected the child's liver. It was determined that there was nothing [REDACTED] did that was irresponsible or indicative of child abuse/neglect.

The safety plan involving the [REDACTED] older son was vacated upon the receipt of the investigation determination and autopsy results which concluded that the child's death was ruled "Death by Natural Causes".

Upon receipt of the autopsy report, both Blair County Children, Youth and Families and the PA State Police [REDACTED]. Blair County Children, Youth and Families submitted the [REDACTED] on 07/02/2013. The mother requested no further services from the agency.

Current Case Status:

Blair County Children, Youth and Families and the PA State Police [REDACTED]. Blair County Children, Youth and Families submitted the [REDACTED] on 07/02/2013.

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

A Child Death Review Team Meeting was not conducted as the case determination was made within 30 days of the oral report.

Department of Public Welfare Findings:

- County Strengths:
The investigation was conducted timely and in close collaboration with the Pennsylvania State Police. Case documentation was comprehensive including medical reports, interviews, risk and safety assessments, criminal complaint documents and case dictation.
- County Weaknesses:
There were no weaknesses noted.
- Statutory and Regulatory Areas of Non-Compliance:
There were no areas of non-compliance noted.

Department of Public Welfare Recommendations:

Blair County Children, Youth and Families should continue to conduct thorough and timely investigations in coordination with law enforcement officials.