



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Ryden Thomas

Date of Birth: 12/23/2011
Date of Death: 02/02/2013
Date of Oral Report: 02/08/2013

FAMILY KNOWN TO:

Indiana County Children and Youth Services

REPORT FINALIZED ON:

08/27/2014

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. Indiana 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>
Ryden Thomas	victim child	12/23/2011
[REDACTED]	sibling	[REDACTED] 2009
[REDACTED]	sibling	[REDACTED] 2010
[REDACTED]	father	[REDACTED] 1988
[REDACTED]	mother	[REDACTED] 1987

***Non-household members at the time of the incident:**

[REDACTED]	caregiver	[REDACTED] 1970
[REDACTED]	caregiver	unknown
[REDACTED]	maternal great grandmother	[REDACTED] 1941
[REDACTED]	maternal great grandfather	[REDACTED] 1938
[REDACTED]	maternal grandmother	unknown
[REDACTED]	maternal uncle	[REDACTED] 1962
[REDACTED]	maternal uncle's paramour	[REDACTED] 1964

Notification of Child (Near) Fatality:

Indiana County Children and Youth Services agency received a [REDACTED] report dated 2/08/2013 regarding the deceased victim child, Ryden Thomas. The report was made by [REDACTED] and stated that following:

- The mother reported putting all 3 children in the tub upstairs with only enough water to cover the children's legs.
- The mother reported that she left the children in the tub and went downstairs to get some towels and the child's [REDACTED] ready.

- When she went back upstairs she found the victim child face down in the tub and she claims to have immediately pulled him out of the water and performed CPR on him.
- The mother reported that she counts on the 3 year old to tell her if anything goes wrong. She also reported that she always baths the children together.
- The mother stated that she was gone for at least 5 minutes, but possibly a little bit longer than that.
- The reporting source (RS) and [REDACTED] are satisfied with the mother's explanation of the situation in that it was accidental and not considered physical abuse but not sure if charges will be filed against the mother.
- The father was at home, but the RS understands that the father was locked in a room playing video games.
- The mother reported that the father relies on her to care for the children.
- The RS believes this was a clear cut situation of lack of supervision because the child passed away as a result of not being adequately supervised.
- When the ambulance arrived at the home, the children were naked and wet so the RS assumes that the mother immediately called 911 after realizing what happened.
- The medics reported that as soon as they got to the home the child was taken to the ambulance wet and naked as he was gurgling.
- The child was pronounced dead at the hospital at 8:32pm.
- [REDACTED] were listed as alleged perpetrators and the report was [REDACTED] [REDACTED] resulting in death; therefore, it was processed as a fatality report.

Summary of DPW Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. The record review consisted of all of the case dictation, safety and risk assessments, information obtained through Releases of Information ROI's, provider reports, the county's fatality report, and the coroner's report. The regional office also participated in the County Internal Fatality Review Team meeting on 3/08/13, and spoke to the caseworker, supervisor and director of Indiana County at that time. Subsequent conversations took place on several occasions to gather updated information, and to request the coroner's report, the [REDACTED], and an updated status on the [REDACTED]

Children and Youth Involvement prior to Incident:

The agency received a call from the father on 2/11/2010 who reported concerns regarding [REDACTED], who was 4 months old at the time. He alleged that he was made to leave the home the previous Monday and the mother would not allow him to visit with his child. He also alleged that the child had a diaper rash due to the fact that the mother and a household member (HHM), [REDACTED], sit at the table doing drugs (mushrooms and marijuana) and neglect [REDACTED]. He also alleged that they were feeding [REDACTED] too much and that she was getting fat. He was told to call the police about the drugs, but stated that mother and HHM had threatened him about calling the police. The risk tag was rated low, but the case was accepted for a GPS assessment with a 10 day response time given.

An attempted home visit was made on 2/19/10, and the caseworker left a note on the door asking the mother to call. The mother called the agency on 2/24/10 and denied the allegations. A home visit was set up for 2/24/10. The caseworker documented that [REDACTED] did not have a diaper rash, and the drug allegations were denied. The caseworker documented that she informed the mother that the case would be closed and that she would be receiving a letter stating such. A safety assessment was completed and deemed the child safe; however, the HHM, [REDACTED], was not listed as a caregiver and was not assessed. The documentation supports that both [REDACTED] and the maternal grandmother were caregivers for [REDACTED] at the time of the report. The dictation did not explain who [REDACTED] was in relation to the mother; however the referral stated that Indiana County had an active case with the mother as a teenager due to truancy while she was living with [REDACTED].

The agency received a CPS report on 10/09/10 from a medical professional alleging that [REDACTED] had [REDACTED] to the right side of her forehead and [REDACTED] on her extremities. The child was reported to also have a slight diaper rash. The mother reported to the referral source that [REDACTED], who was listed as the alleged perpetrator (AP) provided conflicting stories. The report also included information that the parents were involved in [REDACTED]. The risk was rated as low, and assigned a 24 hour response time stating that the AP is not a HHM, nor does she have frequent contact with the child. This information was not accurate (see additional information below). In this referral, [REDACTED] is referred to as the maternal step-grandmother. It appears from the dictation that the agency completed the interview with the parents over the phone as all the entries in the CAPS system are listed as "other". There are no home visits or face-to-face contact with the child documented. A safety assessment was not completed.

On 10/09/10, the agency contacted ChildLine regarding any history on record for the alleged perpetrator, [REDACTED]. The following information was obtained: On 10/04/04, she was indicated for rape, sexual assault, and involuntary deviate sexual intercourse by omission. On 10/20/04, she was indicated for rape, sexual assault, and statutory sexual assault by omission. The victim was her daughter, and there were two different perpetrators of the abuse. [REDACTED] came to the office on 10/19/10 and

was interviewed at which time she stated that she was asked by the parents to care for [REDACTED] for 4 days because no one else was available. She denied causing the injuries. She also stated that she would take [REDACTED] every other week for 2-3 days at a time. She also reported that the parent's home smelled like sewer as she believed the sewer line broke. The Child Protective Service Report (CPS) report was unfounded and the agency closed the case on 10/20/10.

On 1/18/12, a General Protective Service (GPS) report was made alleging that a friend of the father's named [REDACTED] was babysitting the children while the parents went shopping. It was alleged that the parents left the children in bed with [REDACTED]. The parents stated that they received texts from [REDACTED] that there were loud noises coming from the home; the children were screaming. When the parents came home, everything was quiet and the children were in bed. The parents were seeking help for [REDACTED] as they claimed that she had been touching people in their private areas since that night. The case was initially rated as low risk as it was reported that [REDACTED] was not a HHM, but he was the babysitter which generated this report. A 10-day response time was given.

A phone call was made to the mother who reported that [REDACTED] behavior of touching her brother's private area started after they were born, but recently she began touching adults including the father. The mother also reported that [REDACTED] does not like to sleep by herself, is having more temper tantrums, has been known to bite herself until she bleeds, and bangs her head. The mother reported that at first the pediatrician stated that this is normal behavior, but the mother decided to have [REDACTED]. The mother reported that she and the father left at 1:00 am to go shopping and returned home at 5:00 am, leaving the children home with [REDACTED]. During this time, they were texted [REDACTED] telling them that they heard a man screaming and the children were crying. It was also reported that the radio was full blast and that doors were being slammed. The documentation does not state what time they received the texts, only when they arrived home at 5:00 am everything was normal and the children were back sleeping in their own beds. The mother stated that she would no longer allow [REDACTED] to babysit the children, but since he is a good friend of the father's he will be at the home from time to time.

The caseworker completed a home visit later in the afternoon on 1/18/12 and it was documented that the parent's came outside because [REDACTED] was at their home and they did not want him to know that they reported him to CYS. The parents also stated that a CYS caseworker had told them on the phone that it was okay for [REDACTED] to visit, but not to let him alone with the children. They verbally reported to the caseworker that [REDACTED] was not alone with the children while they were on the porch, but the caseworker did not go inside the home to verify this. The parent's asked the caseworker to come back another day.

On 1/20/12, the caseworker completed a home visit which included the parents and the three children. At that time, the mother reported that [REDACTED] was not allowed to come back anymore, but that it was hard for [REDACTED], the father to not hang out with him as

██████████ mother reared him after the death of his father when he was a child. The mother expressed not being fond of ██████████ as he gets upset and angry too easily. The mother provided an example of domestic violence incidents between ██████████ and his girlfriend, and that ██████████ would spend his pregnant girlfriend's cash assistance to buy beer. ██████████ reported that both he and ██████████ had ██████████ problems growing up. ██████████ also reported that he has had several run ins with the police growing up and that one of his angry outbursts led him to ██████████

██████████ The parents reported that ██████████ had been grabbing the father's private area and was also seen "sniffing butts and sniffing down there". The parents reported a concern that ██████████ was delayed. The mother reported the child has seen two different pediatricians and the mother did not believe the current pediatrician is meeting her needs. The caseworker strongly recommended that ██████████ ██████████, and that ██████████ not be left alone with the children for any reason. The caseworker stated that she would check back with the parents to ensure an evaluation for ██████████ was scheduled. It was noted that the father continued to play video games during the entire home visit.

On 1/26/12, the family was referred to the ██████████ ██████████ services. Supervisory logs were maintained on 1/06/12, and 1/27/12, stating "conferred on status of intake". No other information was provided in the logs. An attempted home visit was made on 2/13/12 and ██████████, the maternal step-grandmother (MSGM) answered the door. The MSGM allowed the caseworker to see the children. She also told the caseworker that ██████████ had spent the week-end in the parent's home, and voiced her concern that ██████████ has delays or possibly has been sexually abused because she will not sleep on her own and wants to sleep with the father. Supervisory log dated 2/16/12 stated that the parent's ██████████ needs to be addressed; that ██████████, and that the medical needs of the children need to continue consistently.

On 2/24/12, a supervisory log was maintained and stated that the family had been cooperative; that the mother needs ██████████; that the medical professionals need to do what they feel is needed for ██████████, and if they feel they need to call ChildLine they will; and, the agency continues to work diligently with the family and family is cooperative.

On 2/27/12, the caseworker completed a home visit with the ██████████ who was completing ██████████ at the home. The dictation reflects that the father was "engrossed" in playing his video games and made no effort to participate. The mother reported that ██████████ had been throwing up and had diarrhea on and off for over a week. Both the caseworker and the ██████████ instructed the parents to take him to

either his pediatrician or the emergency room. The workers had to continually remind the mother to redirect the children the entire visit. The previous week, the [REDACTED] observed the father give the children full hot dogs and the parents let them eat in the kitchen alone. It was noted that again there was discussion with the parents regarding supervising and monitoring the children due to the risk of choking. The caseworker also noted that the parents should be working together to support each other instead of the father always playing video games. [REDACTED]

On March 5, 2012, there was a 10 day supervisory log which stated that the case needed to be opened due to time running out per the regulations; [REDACTED] will start in early March; that the doctors need to get a handle on [REDACTED] is working with the family on parenting and time schedules of the children for sleeping, eating routines, etc. At this point, there had been no release of information (ROI) forms obtained for the children's medical care, despite this being a concern.

At a home visit on 3/05/12, the father reported that [REDACTED] had been to the emergency room (ER) in [REDACTED] while he was visiting his relatives. The parents had failed to have him seen by a doctor as directed at the 2/27/12 home visit. The caseworker did not gather the information as to what happened in the ER, nor were the parents requested to sign a ROI for the agency to obtain this medical information. The mother stated that [REDACTED] on-going vomiting and fever were attributed to the fact that he was teething. The mother reported that [REDACTED] continued to visit the home and that [REDACTED] is the babysitter.

The caseworker completed the conclusion of intake safety assessment and there were no threats listed and the children were deemed safe stating that the children can safely remain in the parent's home and a safety plan was not necessary.

A GPS allegation came in on 3/08/12 from [REDACTED] stating that [REDACTED] had what looked to be a burn mark. This was documented as a phone call and it was not entered as a new report, so there was no risk or safety tag, and a response time to see the child was not given. On 3/09/12, the mother called to report that [REDACTED] was being admitted to [REDACTED] Hospital and may be transferred to Children's Hospital of Pittsburgh. The mother was asked about the mark that looked like a burn and stated that [REDACTED] had bitten [REDACTED]. The dictation reflects a discussion with the supervisor to open (accept for services) the case next week.

On 3/09/12, the caseworker spoke to the [REDACTED] at [REDACTED] Hospital who reported that [REDACTED] was 15 months old and weighed only 18 pounds at admission; therefore, there was a concern that he is malnourished. [REDACTED] voiced a concern that the child would go to bed at 8 pm, and he would not get up until 10 am. The caseworker stated that her impression was that the parents stay up all night and sleep in until noon-2 pm. [REDACTED] also reported a concern for the parent's ability to parent, and recommended that the [REDACTED] hours be increased and

expressed her concern regarding the agency's need to continue to closely monitor the situation. There was no documentation of a discussion with the social worker regarding the need to generate a CPS investigation, given the child's malnourishment. On 03/15/12, [REDACTED] was transferred to Children's Hospital in Pittsburgh (CHP).

There was a supervisory log dated 3/15/12 which stated that the family has been cooperative; that [REDACTED] is to have an [REDACTED]; CHP is planning to refer [REDACTED]; and that the case will be opened and transferred next week. On 3/15/12, the [REDACTED] contacted the caseworker to report that [REDACTED] was not doing better and [REDACTED]. It is believed that he is failure to thrive; [REDACTED]. It was also reported that he has a [REDACTED] [REDACTED] also reported that a referral for [REDACTED]. It is also recommended that once he [REDACTED] that he see his pediatrician two times a week to be weighed.

On 3/18/12, the caseworker contacted the pediatrician and left a message on the voice mail stating that she had faxed a ROI to his office asking for the medical records to be released for all 3 children so CYS can view the parent's history of the parents providing for their medical needs. The caseworker never spoke directly to the pediatrician, nor was there any follow-up,

On 3/19/12, the mother contacted the caseworker to state that [REDACTED] had been [REDACTED] CHP at 12:30 pm, but the parents had car problems on the way home and did not get home until 4 pm. [REDACTED]

That same day, the caseworker went unannounced to the home and reported that there were several bottles of Pedi sure but the mother did not have [REDACTED] had given them to the MGM who was caring for [REDACTED] and Ryden. She also reported that [REDACTED] appetite was limited. The dictation states that the father has two other children who live with their mother and are active with [REDACTED] County Children's Bureau, but Indiana County never followed up on this.

[REDACTED] Allegedly [REDACTED] was able to open the door and would often times go outside.

On 4/11/12, the caseworker completed an unannounced home visit at 1:15 pm and everyone was still sleeping. The mother reported that [REDACTED] had an appointment at [REDACTED] in May [REDACTED] that he is still having trouble keeping food down. It was also reported that [REDACTED]. At this point the dictation refers to [REDACTED] as the "MGM's ex-girlfriend." Later that afternoon, the agency received a GPS report from an anonymous reporting source stating that [REDACTED] is currently at the parents' house drinking; that [REDACTED] choked

██████████; that ██████████ was throwing up and has diarrhea and the parents have not taken him to the doctor. It was also alleged that there is no gas for cooking. Again, the agency documented that is a "phone call", so it was not assigned a risk or safety tag and a GPS response time was never given. In response to this, the caseworker contacted the mother the morning of 4/19/12 via phone. The mother reported that ██████████ was eating at the time and there was food on the floor. According to the mother, there is another inspection on 4/24/12 and if they do not pass, the family will be evicted. The mother denied that ██████████ had diarrhea but stated he was throwing up; and that the ██████████

On 4/19/12, ██████████ made an anonymous report to the agency stating that she could hear the father yelling at the kids all of the time and that the kids are always screaming and crying. A phone number was left for caseworker to call, but there was never any follow up with this report. On 4/20/12, ██████████ contacted the caseworker asking to remain anonymous and reported that she witnessed the father grab ██████████ from ██████████ by one arm and threw her in her car seat. Both of these reports could be considered a new GPS referral, but neither was given a risk or safety tag, nor was a response time assigned by a supervisor. The caseworker did not make another home visit until 5/07/12. As with the previous report, the caseworker contacted the mother by phone to address the concerns that were reported.

On 5/07/12, the caseworker completed a home visit and the dictation states that the ██████████ was there completing ██████████. The mother reported that Aiden was not throwing up but still had diarrhea. The agency did not follow up regarding the child's ██████████.

On 5/10/12, ██████████ contacted the agency to report that the father is verbally abusive toward the children; that he yells at the top of his lungs at the children for hours; that the mother is lazy and the father has serious anger issues. This report was documented as a "phone call" and as with the other GPS reports made; a risk or safety tag was never given, nor was a response time provided by the supervisor. The next time the caseworker saw the children in their home was 5/21/12. At this point, the mother reported that because of the father's ██████████ she never allows him to be alone with the children. ██████████ is again a household member. The mother reported that she is now not happy with the current pediatrician. There is no documented collateral directly with the pediatrician or any of the physicians involved in ██████████ treatment from ██████████ to date.

On 6/19/12, the caseworker documented a home visit in which she met with the father and Ryden. The father continued to play video games throughout the visit and Ryden remained in his car seat. The worker pointed out to the father that the mother and other children were upstairs sleeping. It was reported that ██████████ were still coming to the home, but there were no documented collateral contacts for either service.

On 7/11/12, the caseworker completed a home visit; the parents were not home and [REDACTED] was with the children. [REDACTED] again reported that she had been added to the lease for 1 year. She stated that the parents waste their money on junk and do not pay their bills; she also reported that she is tired of the father yelling and hitting [REDACTED].

On 7/13/2012, the caseworker received a call from [REDACTED] stating that [REDACTED] was at the family home and the Pennsylvania State Police (PSP) were there. The caseworker spoke to this reporting source and obtained the following information: [REDACTED] was at the home currently with the PSP, but she was not sure why. The reporting source questioned the caseworker as to why nothing was being done for these children and she reported that the children are beat every day by the mother and [REDACTED]. She also reported that she saw marks on the children's butts a couple of days ago. It was also documented that she reported seeing marks on the children's butts often. Later that day, [REDACTED] called to report that she and [REDACTED] were at the home and the PSP were there allegedly filing charges against [REDACTED] for threatening the parents and harassing them. This worker also reported that [REDACTED] told her that the parents hit the kids. In response to these allegations, the caseworker called the mother and spoke to her on the phone. The mother reported that [REDACTED] and the father had a disagreement over an X-box and that [REDACTED] had been threatening them with physical harm and with burning their apartment down. The caseworker addressed the allegations that she and the father hit the children over the phone. Again, this would be considered a GPS report with new information. There was no safety or risk tag, or response time for the caseworker to see the children. The next home visit was not until 7/19/12. The children were listed as participants, but there is no documentation to support that the children were seen or that the caseworker observed them to see if they had any injuries.

On 7/23/12, the agency received a CPS numbered report with [REDACTED] as the victim child. It is alleged by the reporting source that she was at the home that day and witnessed [REDACTED] to have bruising on her upper left arm, on the inside bend of her left elbow and upper bicep of the left arm. The reporting source reported to asking the parents what happened and the mother reported that [REDACTED] bit [REDACTED]. The RS stated that the injuries were definitely bruises and not bite marks. It was reiterated that a HHM has reported several times witnessing the father pick the children up by their arms and tossing them on a chair or in the car when he gets frustrated and the kids don't listen to him. The RS also stated that upon arriving at the home, the child approached her to show her the marks and told her that it hurts. It was reported that the father is [REDACTED]

[REDACTED] The father admits to having [REDACTED], and the parents have issues with changing the children's diapers.

The caseworker did not see the child within the 24-hour required period when a CPS report is generated. The report was unfounded on 7/24/13. The next documented home visit was not until 8/03/12. It was documented that [REDACTED] was napping on the couch and there was no documentation that the caseworker checked her arm for

bruising; only that she talked to the father about the way he handles [REDACTED] when she does not listen. The father also reported that he had [REDACTED]

On 8/08/12, the agency received an anonymous GPS report stating that the family has a pit bull puppy which allegedly scratched [REDACTED] on his stomach and growled at him. The caller stated that she did not witness this, but was told by another party. On 8/09/12, the agency received another report from an anonymous caller stating that [REDACTED] has huge scratches on his chest; a fist size burn on his right shoulder that he did not have the day before. The caller also reported that the parents were not feeding the dog, nor did the dog ever go outside. It was also stated that the children go outside by themselves because the parents sleep most of the day. It was also alleged that the parents only bought one size diaper for all three children. It was also alleged that two nights ago the baby (Ryden) cried for over 3 ½ hours because the parents allow him to sit in his car seat all day. The RS stated that the car seat had a pool of urine in it and it was soaked. It was also alleged that the parents get their checks and blow it the same day on Xbox games. [REDACTED]

This again would be considered a new GPS referral; there were no safety or risk tags and no response time for the caseworker.

Another GPS report was generated [REDACTED] on 8/16/12 stating that the parents are [REDACTED] and the children are hungry as the family is out of milk. As with all of the GPS reports made, this was not assigned a risk or safety tag, or a response time. The next attempted home visit was not until 8/23/12 and no one was home. The caseworker completed an announced home visit on 8/24/12. At this home visit, the children were listed as participants but there is no dictation to support that the caseworker saw the children other than "the kids look fine". The parents denied [REDACTED] and the caseworker documented that the mother showed her that she has food, formula and PediaSure, but it is not descriptive as to the amount in the home.

On 9/06/12, the caseworker completed a home visit and [REDACTED] was receiving a [REDACTED]

The caseworker completed a home visit on 9/19/12 with the father. He reported things were fine. The children were not seen. [REDACTED]

On 10/24/12, the caseworker visited the home. The mother reported that [REDACTED] was [REDACTED]

On 11/06/12, the caseworker conducted a home visit with the mother, [REDACTED] and Ryden. [REDACTED] Ryden was observed to be in his car seat.

On 11/06/12, a risk assessment was completed by the overall severity and overall risk sections were blank, and the supervisor did not approve this form.

[REDACTED]

On 12/18/12, the caseworker completed a home visit with the parents and the children. The mother reported not having the [REDACTED] and that [REDACTED] is scheduled to return to [REDACTED]. It was reported that neither parent was [REDACTED]. The mother reported still having [REDACTED]

[REDACTED] There were no collateral contacts with these providers.

On 1/07/13, the caseworker completed a home visit with the mother, [REDACTED] and Ryden. The mother reported wanting to change the children's pediatrician again. On 1/09/13; [REDACTED]. The mother was instructed to provide a stool sample the next time [REDACTED] had a bowel movement.

On 2/02/13, the agency received a GPS report [REDACTED] from an anonymous female with the following information: This reporting source has made numerous calls about the parents abusing the children; no one wants to do anything to help the children; she is fearful the children will be hurt or killed by the parents; the RS thinks something may have happened to one of the children tonight (unknown details); the children were currently staying with a neighbor; there is no food in the home; parents [REDACTED]; father has hit the children in the past and picked them up by the arms and throws them; RS is concerned for the safety and well-being of the children; children are fearful of the parents; the children are at risk due to the report being made; and, unknown if children have pain, injury or impairment at this time. At this point, [REDACTED] was disconnected with the caller. The caseworker was instructed to contact [REDACTED], who was believed to be the RS. It was reported that Ryden had drowned in the bath tub around 8:00 pm. The caseworker then contacted the neighbor to see if she had the other 2 children which she reported were with her. She stated that the police asked her if she would watch the children.

The caseworker went to the family residence per supervisory directive at 1:40 pm. [REDACTED] was sleeping in his car seat on the living room floor and [REDACTED] was described as being wide awake and very social and friendly. The mother reported that she always put the 3 children in the tub together but reported only putting enough water so they can play with a certain water toy. Both parents stated that they depended on [REDACTED] to tell them if something were wrong, but that tonight she did not let them know there was a problem. The mother reported that Ryden was very tired as he had been out all day. She admitted that she left the children alone in the tub while she went downstairs and that this was not the first time she had done this. She reported feeling uneasy and going back upstairs to check on the kids and found Ryden face down in the tub. At this

point she pulled him out of the tub and performed CPR and stated that he did cough up some water; but the mother believed he was gone prior to the ambulance arriving. The father reported that he was in the room next door playing computer games with some of his on-line friends when this happened. At this point, the safety assessment was completed listing the threats manifested due to the fact that the mother was not providing supervision while the children were in the tub, resulting in Ryden drowning. The agency assessed that the father was a responsible adult caregiver and could mitigate the threat by supervising the mother's contact with the children. [REDACTED] and [REDACTED] were deemed to be safe with a comprehensive safety plan as stated above.

On 2/03/13, the agency caseworker spoke to the PSP who stated at the time he did not suspect a criminal act, although it is documented that he said that it was criminal negligence. The autopsy was scheduled for later that morning.

On 2/04/13, the [REDACTED] contacted the caseworker to report when she goes to the home to work with [REDACTED]; she had been concerned about the food situation for the children. She did not believe there were any kid friendly foods in the home and has even offered to take the mother shopping, but she declined the offer. The caseworker stated that she has had no concerns regarding the food in the past.

On 2/04/13, PSP reported that they will be obtaining a court order to obtain the CYS case record, and provider records. The case worker reported to the PSP that [REDACTED] [REDACTED] were currently providing services to the family. The DA was to review the information to determine if charges needed to be filed.

On 2/07/13, the mother contacted the caseworker and told her she was staying with friends in [REDACTED]; that [REDACTED] were with the MGGM in [REDACTED] and that the father went to [REDACTED] to stay with his family. The mother reported that she was not to be alone with the children per the safety plan as father was to supervise, but he left and went to [REDACTED], so she made arrangements for the kids to go to her MGGM's, [REDACTED]. Later that afternoon, the caseworker called the MGGP's who stated that they were in agreement to keeping the children longer. The caseworker obtained their demographic information and told them that the mother could visit the children as long as they supervise the contact.

Circumstances of Child (Near) Fatality and Related Case Activity:

The agency received a [REDACTED] report dated 2/08/2013 regarding the deceased victim child, Ryder Thomas. The report was made by [REDACTED] and stated that following:

- The mother reported putting all 3 children in the tub upstairs with only enough water to cover the children's legs.
- The mother reported that she left the children in the tub and went downstairs to get some towels and the child's [REDACTED] ready.

- When she went back upstairs she found the child face down in the tub and she claims to have immediately pulled him out of the water and performed CPR on him.
- The mother reported that she counts on the 3 year old to tell her if anything goes wrong. She also reported that she always baths the children together.
- The mother stated that she was gone for at least 5 minutes, but possibly a little bit longer than that.
- The RS and [REDACTED] are satisfied with the mother's explanation of the situation in that it was accidental and not considered physical abuse by is not sure if charges will be filed against the mother.
- The father was at home but the RS understands that the father was locked in a room playing video games.
- The mother reported that the father relies on her to care for the children.
- The RS believes this was a clear cut situation of [REDACTED] because the child passed away as a result of not being adequately supervised.
- When the ambulance arrived at the home, the children were naked and wet so the RS assumes that the mother immediately called 911 after realizing what happened.
- The medics reported that as soon as they got to the home the child was taken to the ambulance wet and naked as he was gurgling.
- The child was pronounced dead at the hospital at 8:32pm.
- [REDACTED] were listed as alleged perpetrators and the report [REDACTED] [REDACTED] resulting in death; therefore it was processed as a fatality report.

At this point, the agency changed the safety assessment to include both parent's protective capacities to be diminished, with the MGGP's as the responsible party; however, the safety plan only discusses their need to supervise contact with the mother and there is no safety plan regarding the father's contact with the children; and the plan was not signed by the father.

On 2/08/12, the caseworker visited the mother at the MGGP's [REDACTED] [REDACTED]. The mother stated that she did tell the father that she was going downstairs while the kids were in the tub and she looked in the bathroom before telling the father and saw only 2 heads, but didn't think anything of it and went downstairs to get Ryden's [REDACTED] ready. When she started to put the towels in the dryer, she described that something came over her so she went upstairs and that is when she found Ryden face down in the water. It is documented that the mother stated that this was her routine to leave the children in the tub unsupervised. She also stated that [REDACTED] usually would tell her if there was a problem. The mother reported that the father went to [REDACTED] because they can't deal with each other right now. There was a discussion about the fact that the mother was pregnant [REDACTED].

There was no contact with the children or MGGP's during the month of March, 2013

It is not clear at this point when the children went to the MU's home, but there is a documented home visit on 4/08/13 at the uncle's home and the children were living there. This is the point that the caseworker completed a walk-through of the home. A risk assessment was completed this date to include the MU and his girlfriend as caretakers, along with the parents. Overall severity was rated H due to the neglect resulting in Ryden's death; overall risk was rated L at the MU's home, and M if the parents were to be released from jail.

On 4/11/12, the mother was released from jail to the MGGM's home with an ankle bracelet as she was put on house arrest. There is an adult probation officer assigned to the mother and it is court ordered that she have no contact with the children. The PO stated that the reason she was released is due to the fact that she is pregnant.

The mother's preliminary hearing was held on 5/13/13 and all of the charges were dropped by the Magistrate except for the misdemeanor child endangerment charges. The father waived his right to the preliminary and was release on bond and ordered to stay with his paternal aunt in [REDACTED]. Neither parent is allowed contact with the children,

On 5/14/13, the caseworker visited the MU's home and was informed that the MU and his girlfriend could no longer care for the children due to the children's negative behaviors (temper tantrums and fighting).

Om 5/16/13, the agency [REDACTED] to place the children in foster care. MGM in [REDACTED] continued to call stating an interest in caring for the children. A paternal aunt in [REDACTED] was also interested in caring for the children. It is documented that the foster mother picked the children up to transport them to her foster home. There was no documented foster home visit to see the children in their living environment for the months of May or June.

On 5/21/13, the agency received the coroner's report stating that Ryden died as a result of drowning and the manner of death was deemed accidental.

[REDACTED]

Current Case Status:

On 6/17/13, the agency was notified that the mother gave birth to a son [REDACTED] who weighed 7 pounds, 15 ounces and was 19 inches long. On 6/19/13, the agency was notified that the mother and baby were [REDACTED] the hospital. The agency allowed the mother [REDACTED] with the baby since she was living with the MGGP's; however a home visit was not completed until 6/24/13 at which time a safety assessment was completed determining that [REDACTED] was safe with a comprehensive safety plan. The safety plan states that all interaction with the mother and [REDACTED] needs to be supervised by the MGGP's. A new risk assessment was also completed to include [REDACTED], with the same results of the above risk assessment findings.

The first documented foster home visit was 7/15/13. The foster mother has had ongoing contact with the MGGP's who report to her that they are the ones doing all of the work caring for [REDACTED]; that the mother does not help at all. A concern identified in the dictation is the fact that [REDACTED] crib is described as being along the wall inside the mother's bedroom as the MGGM's bedroom is too small for the crib.

[REDACTED]

At one point the MGGF came to the CYS office for an opportunity to speak alone with the caseworker. The MGGF reported that he and mostly his wife were doing all of the work caring for [REDACTED] and given their ages of 71, and 77 he was not sure how much longer they could manage. When the caseworker spoke to the mother about this, the mother stated that she does not want to hold [REDACTED] or help take care of him because she does not want to get bonded to him because she might have to go back to jail.

On 8/05/13, the Indiana County DA's office re-filed criminal homicide charges (3rd degree murder), aggravated assault charges, recklessly endangering another person, and endangering the welfare of the child charges. The preliminary hearing was continued. The mother remains on house arrest at the MGGP's, awaiting her trial date. The father remains in [REDACTED] and waived his right to the preliminary hearing and is awaiting a trial date.

[REDACTED]

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

- Strengths: Community services were being provided. The parents were cooperative with providers by allowing access. The mother was compliant with well-baby checks, immunizations and maintained appointments with doctors at CHP. [REDACTED]. Services were in the home weekly. The family donated Ryden's tissue and organs.

- Deficiencies: There was double scheduling of service providers, many providers, all with ongoing concerns with lack of supervision. There appeared to be a lack of support for the mother raising 3 children under 3.
- Recommendations for Change at the Local Level: There needs to be more direct communication between agencies to the right people about concerns and recommendations to ensure safety of children. Service providers often share information with CYS, but not the other providers involved with the family. Often the service providers don't know all the players involved with the family. CYS is the primary case manager with the family and knows about all the services. It is recommended that a quarterly meeting be held with the service providers. If a case is High risk, identified as those with more than 3 service providers, a team meeting should be held to discuss the case and services being provided.
- Recommendations for Change at the State Level: none were identified.

Department Review of County Internal Report:

The county report was not received until the end of July when the assigned program representative discussed with the Director the fact that the region had not yet received the report. The Department discussed the report with the director at that time. The Department concurs with most of the county's findings in the report; however, the Department identifies other areas of concern regarding the case practices utilized to provide services to this family. These are detailed below.

Department of Public Welfare Findings:

- County Strengths: The Department agrees that strength was the fact that the agency referred community service providers to assist the family, and provided transportation for [REDACTED] medical appointments.
- County Weaknesses:
- There were ongoing GPS reports regarding possible abuse/neglect of the children made directly to the assigned caseworker. It is concerning that the agency did not consider these allegations to be a new GPS report and it appears as though there was never a review of the allegations by a supervisor, as there was no risk or safety tag identified, and a response time was never given. Most of the time, the caseworker would address the allegations over the phone, and efforts to actually see the children in their living environment did not seem to be a priority.
- The agency made no effort to bring all of the parties working with the family together for a team meeting to discuss the concerns, nor did the caseworker communicate the numerous concerns brought to her attention by one service provider to the other providers involved with the family.

- In all of the dictation of home visits by the caseworker and validated by the service providers, it is noted that the father was always playing video games on X-box during the visits. There was no effort documented to attempt to engage the father and complete an assessment on him.
- There was no documentation regarding an interview with the father regarding the CPS investigation. His account of the events is not documented after the [REDACTED] report was generated.
- Releases of information were signed by the parent's, but little if any collaterals were documented with the children's PCP or the parent's [REDACTED] providers. There is a concern that the agency did not pursue a CPS investigation at the time [REDACTED] was [REDACTED]. After he was hospitalized for this at CHP, there were no direct collaterals with any of the physicians [REDACTED] at CHP or with his PCP [REDACTED].
- There was no professional documentation as to what the parent's [REDACTED] actually were, and what [REDACTED]. There were no collaterals with any of the [REDACTED] providers regarding conflicting information provided by the [REDACTED].
- After Ryden's death, the agency initially entered into a safety plan for the father to provide supervision of mother's contact with the children. This is very concerning considering that the dictation mentioned above (X-box) and the fact that it was also clear in the dictation from the caseworker and the service providers that the father was not involved in the care of the children; that the mother provided sole care.
- The agency [REDACTED] and allowed the children to be under a safety plan signed by the mother from the time of Ryden's death on 2/02/13 [REDACTED] on 5/16/13.
- [REDACTED] despite the fact that the mother admits that she does not want to bond with him due to her fear of going back to jail; and, the fact that the MGGP's who are in their 70's have voiced concerns that they are providing sole care for [REDACTED].
- The agency did not complete an assessment on the people who were caring for the children, which is concerning given the information available to them regarding the caretakers histories.
- There is little if any documentation to support that the caseworker has followed up to ensure that [REDACTED] medical, behavioral, developmental and over all well-being needs were being met while in the care of the parent's or since they were placed in a foster home.

- The agency has not filed interstate compacts for the MGM in [REDACTED] or for the paternal relatives in [REDACTED] to request a home study for the families to make efforts to place the children with relatives, [REDACTED]
- The agency placed [REDACTED] with relatives via a safety plan and there was no documentation to support that the agency discussed the option of becoming a kinship care provider. The agency did not provide any support to the relatives for the care of the children.
- Statutory and Regulatory Areas of Non-Compliance:
- 3490.55 (d): The agency did not interview the father who was an [REDACTED] [REDACTED] on [REDACTED] report regarding Ryden's death.
- 3130.21 (b): The agency utilized a safety plan for [REDACTED] from 2/02/13 to 5/16/13 at which time the children were placed [REDACTED]. This is a violation of Bulletin 3490-06-01, Safety Assessment and Planning Process, dated March 15, 2006.
- 3130.21 (b): The agency is in violation of Fostering Connections to Success and Increasing Adoptions Act of 2008 as they have failed to make due diligence to identify all relatives to the fifth degree for placement options for [REDACTED]. This would also apply to the new baby [REDACTED], who is in the care of his MGGP's.
- 3130.21 (b): The agency has not yet filed any interstate compacts to have the relatives assessed, which is also a violation of Bulletin #99-08-01, Implementation of Safe and Timely Interstate Placement of Foster Children Act, effective 10/01/06.
- 3130.21 (b): The agency failed to comply with the Adoption and Safe Families Act which also states that relatives must be given first consideration as a placement option for children.
- 3130.21 (b): The agency continues to violate The Adoption and Safe Families Act regarding aggravated circumstances that exist surrounding Ryden's death. The agency should have filed a petition for dependency for [REDACTED], with the aggravated circumstances, as opposed to placing him in the MGGP's home on a safety plan, which is also where the mother is [REDACTED].
- 3130.21 (b) The agency failed to comply with the Kinship Care Policy Bulletin #00-03-03 as they have not offered the MGGP's the option of being paid kinship care providers.

Department of Public Welfare Recommendations:

The Department recommends that Indiana County review the policies and procedures in place regarding CPS and GPS investigations and assessments. The agency needs to be proactive in setting up team meetings when multiple providers are involved with a

family to ensure that all parties have the information necessary to best meet the safety, permanence and well-being issues of the children receiving services. The agency needs to review its supervisory protocol regarding the need for supervisors to review any new GPS allegation that is made, to ensure, appropriate responses are made to the allegations. The agency needs to enhance its practice efforts regarding cases that have been accepted for services, which should include regularly documented supervision with the caseworkers. The agency needs to review its practice regarding reviewing high risk cases with the county solicitor to determine if there are grounds for dependency.