



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

**REPORT ON THE Fatality OF:**

*Grace Rough*

**BORN: December 13, 2010**

**DIED: July 20, 2013**

**DATE OF REPORT: July 22, 2013**

**FAMILY KNOWN TO:**

*Crawford County*

*Children and Youth Services*

**REPORT FINALIZED ON:**

08/10/2015

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. 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. Crawford 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>
Grace Rough	victim child	12/13/2010
[REDACTED]	mother	[REDACTED] 1992
[REDACTED]	half-sister	[REDACTED] 2012
[REDACTED]	step-father	
[REDACTED]	maternal grandmother	[REDACTED] 1969
[REDACTED]	maternal uncle	[REDACTED] 1991
[REDACTED]	maternal uncle	[REDACTED] 1995
[REDACTED]	maternal uncle	[REDACTED] 1996
[REDACTED]	maternal uncle	[REDACTED] 2000
[REDACTED]	maternal uncle	[REDACTED] 2002
[REDACTED]	maternal aunt	[REDACTED] 1993
[REDACTED]	cousin	[REDACTED] 2012
[REDACTED]*	maternal uncle	[REDACTED] 1999

\*Please note that [REDACTED] died on 8/27/1999

**Notification of Child (Near) Fatality:**

On 7/22/13 Crawford County CYS, (CCCYS) received a [REDACTED] report that on 7/20/13 while the child was in the care of the maternal grandmother that she had drowned in the backyard pool. The report stated that the child had missing for forty five minutes before she was found. The child was not properly supervised. [REDACTED] registered the report 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 child's family, the maternal grandmother's

family, and the maternal aunt's family. The Crawford County Coroner's Death Investigation Report was reviewed by the Region. The regional office also participated in the County Multi-disciplinary team meeting on 8/23/13

### Summary of Services to Family:

#### Children and Youth Involvement prior to Incident:

##### Child's Family:

This was the first referral to the agency on the victim child's family.

##### Maternal Grandmother's Family:

CCCYS became involved with the family in 1999. At that time the maternal grandmother was a thirty year old woman with six children. The children's ages ranged from nine years old to a newborn. There were four boys and two girls. The maternal grandmother had a job and was purchasing her house. The identified issue was housing conditions. In August of 1999 the agency received referrals on her fourth son who was the baby born in May of 1999. The reports were that the maternal grandmother had thrown this child on the bed at the age of one month. Additional reports were that the maternal grandmother was missing medical appointments for this child. The agency was investigating these reports when they were notified that on 8/27/99 while the family was visiting in [REDACTED] that the maternal grandmother who was sleeping with the child rolled over on him and suffocated him. The death was ruled an accident. It was noted in the dictation that the maternal grandmother did not appear upset about the child's death and wanted to move on with her life. The maternal grandmother was then laid off from her job. [REDACTED]

[REDACTED] The case was closed in July of 2000 when the home conditions had improved.

From 2001 to 2006 the agency received a number of [REDACTED] referrals on the family. The issues that were reported to the agency concerned housing condition, cleanliness of the children and the supervision of the children. These referrals were investigated by the agency services were offered to the family and the case would be closed.

In 2007 the agency received a [REDACTED] report that the maternal grandmother's oldest son (who was 16 at the time) had sexually assaulted his two sisters one of which is the victim child's mother. The victim child's mother initially cooperated with the investigation however once she realized that her brother was going to be charged with sexually assaulting her and her sister she refused to cooperate [REDACTED]

The case was opened and services were provided by a blended case manager to provide



with her and her maternal uncles while the mother went to the store to pick up diapers. The child asked for a cheese stick and the maternal grandmother went and got her one. Maternal grandmother reported that she stopped to check the clothes dryer. She could not find the child and summoned her sons to go look for her. It was only a matter of minutes before the child was found at the bottom of the above ground pool. She summoned a neighbor who she knew was an EMT, he immediately started performing CPR and 911 was called. The grandmother stated that there was a gate on the pool deck but it had been left opened. She believed that neighborhood children had left the gate open. She said that CPR was still being performed when the child was transported to Meadville Medical Center. [REDACTED] Doctor told the Coroner that it was a minimum of forty minutes to an hour from the time of the incident to when the child was transported to the Emergency Room. The child had no spontaneous respirations or heart activity. All life saving measures were ceased at 16:27 hours. The Coroner ruled that the cause of death was Asphyxiation by Drowning the manner of death was Accidental.

On 7/22/13 CCCYS received a call [REDACTED] that the child had drowned in the family's pool on 7/20/13. According to the caller the mother had brought the child and her younger sister to the maternal grandmother's home because she is having marital problems. The mother is a good mother to her children. The maternal grandmother's home is a filthy mess and she has a history of not supervising her own children. The grandmother was heard saying that the child was missing for a minute or two but the caller knows that the child had been found unsupervised in the neighborhood before. The family is blaming the mother's sister who is slow for the child's drowning. The sister was not home at the time but she reportedly left the gate open. There is a padlock on the gate now but there never was one there before. [REDACTED]

The caller also expressed concerns about the mother's sister who was described as being mentally challenged and her child who are in the home. The caller stated that the mother sister was not getting medical care for her child. She said that this child almost choked on a piece of paper because the house is so filthy.

After receiving this report the agency reported the drowning [REDACTED] The agency then decided that [REDACTED] would be conducted on the maternal grandmother and her children and the mother's sister and her child.

The caseworker attempted to contact the child's mother but was unable to. The caseworker then went to the maternal grandmother's home and had brief conversation with her. The grandmother told the caseworker that she was eating a cheese stick and that the child wanted one. She went and got a cheese stick for the child and came back and sat down on the recliner within a few minutes she realized that the child was missing and she could not find her. The child's seventeen year old uncle was looking for the child and found her in the pool. He told the maternal grandmother to call 911. A neighbor who is an EMT performed CPR on the child. The ambulance was at the home quickly and took the child to the hospital. According to the grandmother the maternal

aunt had left the gate to the pool open. Her four sons were now not in the home they were at Boy Scout camp. The maternal aunt's child was with his father. The mother and her surviving child were staying with friends [REDACTED]. Two days later the caseworker met with the maternal grandmother and maternal aunt. He told them that he knew that the father and paternal grandmother had petitioned the court for the child. [REDACTED]

[REDACTED] The house needed to be cleaned. The grandmother agreed to do that.

On 7/26/13 the casework supervisor spoke to the County Coroner. He reported that he responded to Meadville Medical Center on 7/20/13 and the entire family was there. They were distraught and had difficulty focusing. According to the Coroner the child appeared to be in very good health and clean. There was no evidence that the child had been neglected or abused. He had no concerns that the child's death was anything but an accident. The Coroner also reported that the maternal grandmother had been very upfront with him about her own experience when her child died.

On 7/30/13 the caseworker met with the mother and the child's sister at the friend's home where she was staying. The mother told the caseworker that she and her husband had been having relationship problems. She had taken her two children and was staying with her mother. The mother was not at home at the time of the incident. She said that it was her understanding that her mother had given the victim child an ice cream sandwich and the child wanted a cheese stick. The maternal grandmother went and got the child a cheese stick and then checked on the laundry. The child was left unsupervised a few minutes. The mother stated that she does not fault her mother for the child's death. The victim child loved to swim and would have gotten to the pool as soon as she could. The mother said that there was a lock for the gate but there were children in the neighborhood who use the pool and the lock was not being put back on the gate. The mother said that it was too hard to stay at her apartment in [REDACTED] so she was going to stay with friends for awhile. The caseworker observed that the victim child's sister was clean and appeared to be a happy and healthy. The caseworker discussed with the mother services [REDACTED].

The caseworker spent the next couple weeks trying to contact the neighbor who performed CPR on the child and coordinating with the Pennsylvania State Police on interviewing the maternal grandmother.

The caseworker spoke with the mother again on 8/13/13. He reiterated with her that the maternal grandmother could not be a babysitter for the victim child's sister. She agreed that she would not use her mother as a babysitter. She also told him that she did not need assistance connecting with services. On the same date the caseworker spoke to the child's sister's father. He told the caseworker that prior to the incident he did not have any issues with the maternal grandmother watching the children. Now he wasn't comfortable with his daughter being watched by her.



On 8/28/14 the caseworker met with the mother and the child's sister. The mother told him that she and her husband were going to work on their problems and they planned to move back in together. She told the caseworker that she was not allowing the maternal grandmother to babysit the child's sister. [REDACTED]

The agency completed [REDACTED] Report on 9/19/14. [REDACTED]

### **Current Case Status:**

The agency closed the case on the mother and her family at the completion of [REDACTED]

The agency opened a case on the maternal grandmother and her family. In-Home services were provided to the family to help the grandmother with setting consequences for her sons. They also helped the grandmother with improving the housing conditions. Each of the grandmother's sons was involved in after school activities. The grandmother told the caseworker that she would [REDACTED] The case was closed in November of 2013.

The agency remains open with maternal aunt's family. The father and the paternal grandmother have custody of the maternal aunt's child. The maternal aunt is receiving [REDACTED]. The maternal aunt has her child every other weekend. The maternal aunt continues to live with the maternal grandmother. There are issues with the clutter in the home. [REDACTED]

[REDACTED] The maternal aunt's son is developmentally on target and is up to date on his medical care.

### **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. Crawford County has convened a review team in accordance with Act 33 of 2008 related to this report. The Multi-Disciplinary Team meeting was held on 8/23/13.

- **Strengths:** The attendees of the meeting included a cross section of individuals who work within in the Human Service system. There was a representative from Meadville Medical Center. Many of the participants had worked with the maternal grandmother's family in the past. They were able to offer their insight into the families functioning.

- Deficiencies: No deficiencies were identified.
- Recommendations for Change at the Local Level:  
There were no recommendations made for change at the local level.
- Recommendations for Change at the State Level:  
There were no recommendations made for change at the local level.

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

Crawford County submitted their internal report to the Department on 10/18/13 which was within 90 days of the review teams meeting. The report offered a summary of the agency's past involvement. The agency's summary of the grandmother's past history was taken from the agency's electronic record keeping system. There was history on the maternal grandmother's family that pre-dated the agency's electronic record keeping system that was reviewed by the Department that was not included in the report. This matter was discussed with Crawford County Human Services Associate Director. The agency will make sure that for future reports that they will check for case history that predates the electronic record keeping system. There was also a discussion that the county needs to include recommendations for change on the local and state level. The Human Service Associate Director stated that the last report that they received had this recommendation.

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

- County Strengths: After receiving the report of the incident the agency realized that they were dealing with three separate families. The agency conducted an investigation on each family. The strengths and needs were identified for each family. The services that were offered were specific to each family. The case decisions that were made were specific to each individual family. The agency met the required timelines to complete the investigations.
- County Weaknesses: No weaknesses were identified.
- Statutory and Regulatory Areas of Non-Compliance: There were no statutory or regulatory area of non-compliance

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

- For future reports the agency needs to check all of their record keeping systems to ensure that all of the family's history is reviewed.
- For future reports the agency needs to include recommendations for change on the state and local level.