pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Bradley Shiffer

Date of Birth: 05/06/2013
Date of Death: 07/06/2013
Date of Oral Report: 07/06/2013

FAMILY KNOWN:

Crawford County Children and Youth Services

REPORT FINALIZED ON:
July 13, 2015

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)

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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 Children and Youth Services (County) has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
[redacted]	Mother	[redacted]1997
	Father	[redacted]1996
	Maternal Grandmother	[redacted]1974
	Maternal Grandfather	[redacted]1966
Bradley Shiffer	Victim Child	05/06/2013

Notification of Child Fatality:

The child was taken via the mother's vehicle to Meadville Medical Center on 7/3/13 following an incident where the child coughed until he turned grey, his breathing was labored and his pulse had risen to 175 to 190 beats per minute. His temperature was 100.4 degrees, his respiratory rate was in the 80's to the 100's and he only weighed 6 lbs, 2 oz. [redacted]

On 7/4/13, the child was transported to Children's Hospital in Pittsburgh via ambulance [redacted] The mother did not escort the child to Children's Hospital in Pittsburgh. The child passed away on 7/6/13 at Children's Hospital of Pittsburgh. An initial call about concerns in the home was taken on 7/6/2013 by the Crawford County Children and Youth Services on call caseworker. A home visit was completed on this same date by the on call caseworker.

Dr. [redacted] from Children's Hospital of Pittsburgh reported that the child died due to sepsis [redacted]

[redacted] Meadville Medical Center had called in the initial report [redacted]

Summary of DPW Child 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 regional office also participated in the County Internal Fatality Review Team meeting on 8/23/2013 where copies of the medical records and discussion concerning this case occurred. The Western Region Office of Children, Youth and Families also reviewed the final report submitted by the County.

Children and Youth Involvement prior to Incident:

On 2/9/12, a [redacted] report regarding the mother as a child was received. It was alleged that the she was "lying and back talking" to her father. The maternal grandfather backhanded her in the right eye. The allegations of bruises were unfounded on March 9, 2012. The case was closed on this same date.

On 3/21/2013, [redacted] report regarding the mother as a child was received. It was alleged that the mother had been punched in the eye by her father, that he had thrown her down the stairs and that he had sexually assaulted her. At that time she was 4-5 months pregnant with her boyfriend's child. A forensic interview was conducted on March 26, 2013 at which time she denied all allegations and stated that she is not sure who would have called in something like this but she believes it was the father to her unborn child. [redacted] The allegation of sexual assault was unfounded on April 19, 2013. The case was closed on this same date.

There was no prior history of Crawford County Children and Youth Services being involved with the mother and her child.

Circumstances of Child Fatality and Related Case Activity:

The victim child was born premature at Meadville Medical Center. He was jaundiced [redacted] he was transferred to Hamot Hospital in Erie, Pennsylvania. He [redacted] his mother's care a few weeks later.

Approximately 3 ½ weeks prior to the [redacted] report on July 6, 2013, his mother took him to [redacted] and reported that the child had been coughing and had congestion. He was treated and sent home. On July 3, 2013, the mother and maternal grandmother (MGM) went back to the pediatricians and reported that the child had been doing better and the cough was improving, but in the last few days he was having difficulty breathing and was coughing harder. Physicians [redacted] sent the child to the Meadville Medical Center for concerns of failure to thrive during this appointment.

When the child came to Meadville Medical Center it was reported that the child coughed until he turned grey. The child was breathing hard and his pulse was raised to 175-190 BPM. His temperature was 100.4 degrees and he only weighed 6 lbs 2 oz. [redacted]

On July 4, 2013the victim child was transported to Children's Hospital of Pittsburgh [redacted] It was reported [redacted] that the mother could not be reached as mother did not come to the hospital with him. [redacted] The child died on July 6, 2013. The child died due to sepsis.

It was reported that the mother is extremely young and seemed like she was more concerned with getting out of the hospital than with the child. It was reported that someone had to stay with the child and the mother turned to the maternal grandmother and said 'I guess you are going to have to stay with him because I'm not'. The child's father is not involved. The mother and maternal grandmother appeared disinterested while at the hospital. The mother and maternal grandmother never spoke to the child or interacted with the child when at the hospital. The mother did not accompany the child to Children's Hospital of Pittsburgh.

A home visit was completed on July 6, 2013. The caseworker met with the mother and her parents. The mother did not appear emotional or upset about the child's death today. Her parents came downstairs and the caseworker talked to them. The Crawford County Children and Youth Services County caseworker explained that he was there because the agency had received a report. The grandmother said that they got a call from Children's Hospital of Pittsburgh last night that they had to go there. They called a cab and at 1:00 am were on their way to the hospital. They reportedly just got home about 2 hours prior to the worker's visit. The grandmother asked the caseworker about [redacted] The caseworker suggested she call the office Monday morning and they could provide her with phone numbers. The home visit was concluded.

On July 11, 2013, the intake caseworker was directed by the Assistant District Attorney, not to interview the family until the police had completed their interviews.

[redacted] on September 3, 2013 and the case was closed at this time.

Current Case Status:

The case is closed due to no other children residing in the home.

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

Strengths:

Relevant information in regards to the situation surrounding the death of the child was gathered diligently by the County intake department in order to make an informed decision [redacted]

The intake investigation began immediately when the [redacted] referral was received. Within hours of receiving the report the CYS intake department met with the family.

The intake investigation was completed within the 60 day time frame; however it is noted that the attempt to obtain records in a timely manner from the Children's Hospital of Pittsburgh did not occur. The County caseworker made several attempts to gather information about obtaining the records and calls were not returned timely to the County by the hospital.

The mandated paperwork was completed timely, and appropriate referrals were made for the family. To aid the family in processing the death of a child, [redacted]

The County communicated efficiently and effectively at the intake level for [redacted] in efforts to gather information surrounding the death of the child.

Deficiencies:

The father in this case and in all cases that are investigated should be consistently identified, assessed and engaged.

Recommendations for Change at the Local Level:

NONE

Recommendations for Change at the State Level:

None

Department Review of County Internal Report:

The county report was received and approved by this office. The County was notified by mail that their report was accepted.

Department of Public Welfare Findings:

County Strengths:

The Department is in agreement with the County strengths as listed above

County Weaknesses:

Engagement of father(s) in the future should be explored further.

Statutory and Regulatory Areas of Non-Compliance:

None

Department of Public Welfare Recommendations:

No recommendations at this time.