pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Sophia Hoffman

Date of Birth: 09/23/2011
Date of Death: 11/17/2013
Date of Oral Report: 11/15/2013

FAMILY NOT KNOWN TO:

Clearfield County Children Youth and Family Services

REPORT FINALIZED ON:

09/18/2014

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))

Office of Children, Youth, and Families, Western Region
11 Stanwix Street, Room 260; Pittsburgh, Pennsylvania 15222 | 412-565-5777 | F 412-565-7808 | www.dpw.state.pa.us

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. Clearfield County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

Name:	Relationship:	Date of Birth:
Sophia Hoffman	Child	09/23/2011
* [redacted]	Mother	[redacted]1993
[redacted]	Father	[redacted]1992
[redacted]	Father's Girlfriend	[redacted]1995
[redacted]	Paternal Grandmother	

*Not a household member

Notification of Child (Near) Fatality:

Clearfield County Children, Youth and Family Services received a call on November 15, 2013 that a 2 year old child was brought to a local emergency room with head injuries and was unresponsive. The child was brought to the hospital via ambulance after [redacted] requested emergency response due to the child's unresponsive condition. The child was in critical condition and was being flown to Children's Hospital for further treatment.

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 family. This would include the investigation initiated at the time of the child's fatality, past records involving the mother as a youth in Elk, Clarion, Clearfield and Jefferson Counties and reports involving the mother as a resident of Elk County. Follow up interviews were conducted with the Elk County Supervisor, the Clearfield County intake Supervisor and Clearfield County Director. The regional office also participated in the Clearfield County Internal Fatality Review Team meeting on December 16, 2013.

Children and Youth Involvement prior to Incident:

Elk County: February 2013. A report was screened out after a call was received regarding concerns of the mother abusing drugs. The subject child of this report was in the custody of the mother at the time, however was in the physical care of the paternal grandparent. The child's father petitioned for emergency custody and was granted legal custody of the child. The child was not returned to the mother by the grandparents and was instead sent to the father's home. Mother had no contact with the child once father obtained custody. Due to the custody order and the fact that the arrangement was not handled by Elk County, the county screened the call out.

There was no other identified involvement of the child in any other county.

PRIOR INVOLVEMENET WITH MOTHER AS A YOUTH:
The mother, as a youth, had prior history with four separate counties. Those counties being Elk, Clarion, Clearfield and Jefferson. Western Region reviewed all of the available documentation regarding the mother's involvement as a youth in each of the mentioned counties. In summary, the mother as a youth was active through CYS and JPO services between the years 2002-2010, sporadically. Most significantly, the reports describe her as having a [redacted] as a youth. Additionally, as a youth, the mother was involved in heightened parental conflicts and inappropriate relationships. The mother was never indicated as a perpetrator in any of the incidents reviewed when she was a child.

Circumstances of Child Fatality and Related Case Activity:

The child was brought to the hospital via ambulance after [redacted] requested emergency response due to the child's unresponsive condition. Upon admission, it was reported that the child's father had left for work the morning of the incident, November 15, 2013, around 5:00am. The father's girlfriend was left to care for the child. The father reported that he had checked on the child, who was still asleep when he left the home. The caregiver woke up around 7:00am. Approximately 30 minutes later, she went to check on the child, who was awake. The caregiver reported that the child was able to walk around the living room and use the potty chair. When she attempted to begin dressing the child, the child appeared to faint. She reported the child's eyes were only half open, she appeared pale in appearance and was not moving. She then transferred the child to the couch and noticed her breathing to be inconsistent and the child was making snoring and wheezing noises. The caregiver then called the paternal grandmother and asked her to listen to the child's breathing over the phone. The grandmother reported the noises sounded like snoring and thought the child was probably still ill and needed to sleep. The caregiver then called a female friend who responded to the home at approximately 8:00am. A second call was made to the paternal grandmother and it was requested she come to the home. Upon arrival, the grandmother told the caregiver to call the ambulance. The emergency call was made at approximately 8:45am. The ambulance arrived approximately 20 minutes later and transported the child to the local emergency room. The child was flown from Clearfield to Children's Hospital in Pittsburgh where she was diagnosed to have bruising to her forehead and shoulders, a split lip and [redacted] The child was certified to be in critical condition. A supplemental report was received on November 18, 2013 indicating that the child had been

pronounced dead on November 17th. Further medical examination had determined the child to [redacted] was registered as the alleged perpetrator.

[redacted] it was discovered that the father had transported the child to a different hospital the prior evening due to concerns with the child vomiting and not eating. The father reported that he had noticed that the child had started to look pale and was developing rings under her eyes a few days prior to the incident. She had bouts of vomiting and appeared more tired than usual. The father thought the child may be developing the flu and decided to take her to the hospital on November 14, 2013. The child was seen at the hospital and sent home. There had been no blood work or imaging done at this visit. Later in the evening, the child was reported to be acting "more like herself". The child was put to bed in her pack and play, in her own room, and slept through the night.

Additionally, the father reported that on October 8, 2013 the child had seen her primary care physician due to showing slight bruising around her eyes in what looked similar to "raccoon eyes". The child was given facial, chest and abdominal X-Rays at the October 8th appointment. There were no findings of concerns at that time. The paternal grandmother took the child for a follow up appointment only days later and the child appeared to be doing well and the bruising had subsided. The paternal grandmother reported that the child had been seen having a tantrum in her pack and play and was banging her head prior to the initial appointment on October 8th. The next appointment was scheduled for October 28th, however the appointment was rescheduled and the child was seen instead on November 6, 2013. She was again transported by the paternal grandmother. At this appointment, it was reported that the bruising was coming back, the child was often hungry and was noticeably beginning to lose hair. The child was referred [redacted]. The child was not able to be seen by [redacted] before the events on November 15th.

Current Case Status:

Clearfield County was not able to determine without doubt when the injury occurred based on the history of reported concerns over the month of October. [redacted] status was submitted on January 13, 2014. [redacted] subsequently submitted to a polygraph later in the month of January, to which [redacted] reportedly "passed". [redacted] has refused the polygraph. Autopsy and toxicology reports are still being processed and charges are being held until results are concluded regarding the manner of death. The agency has closed the case as there are no other children in the home.

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

- Strengths: The agency responded to the hospital and obtained pertinent information regarding the investigation in a timely manner.

- Deficiencies:
  - The most significant concern noted during the county's local review involved the fact that no referral was made to Elk County Children and Youth when the child had been ordered to live with the father. It was noted that the father obtained custody due to the mother's significant drug abuse. The father had recently been released from jail for drug related crimes prior to obtaining custody; however a referral to Clearfield County Children, Youth and Families to assess the family was never made by Elk County Children and Youth Services.
  - The child was seen on three separate occasions, October 8th, November 6th and November 14th by medical personnel due to concerns that she had developed bruising around her eyes. Medical testing was only conducted at the October 8th appointment, and no definite diagnosis was provided. The physician who saw the child on November 6th did not conduct any medical tests to determine the cause of the child's bruising around her eyes, but referred her to [redacted]. The local Children, Youth and Families Office never received any form of notification regarding any concerns [redacted] after these three medical appointments even though the child had bruising under her eyes [redacted]

- Recommendations for Change at the Local Level:
  - Consideration for drug testing for all caregivers involved in [redacted] cases where there is a report of a fatal or life-threatening injury.
  - The agency attempted to secure custody of the deceased child's body to ensure a full autopsy was completed on all of the significant organs. The agency lost the request and the child's organs were secured by the Center for Organ Recovery & Education (CORE) on the day of the death. The local review revealed concerns for future criminal investigations when a child's organs cannot be secured by the investigating county, limiting any request for full autopsy examinations. It was recommended at the county level to further research the capacity of a county agency to secure medical rights of a child after a child fatality to possibly prevent organ harvesting during a criminal investigation.
  - More education should be provided to medical personnel to identify signs of child abuse and neglect along with how to report suspected child abuse.

- Recommendations for Change at the State Level:
  - Improved education for medical professionals regarding emergency response and critical time delays when treating children with such significant injuries. It had been reported to the local review team that the transferring hospital delayed critical treatment to the child due to the amount of time passing before the child was flown to Children's Hospital. Additionally, the treating hospital the day prior failed to recognize possible signs of child abuse and sent the child home without any medical testing.
  - More education should be provided to all medical personnel to identify signs of child abuse and neglect along with how to report suspected child abuse.

Department Review of County Internal Report:

The Department received the county report on February 18, 2014. The Department had no concerns regarding the content of the report.

Department of Public Welfare Findings:

- County Strengths: The Department would concur with the agency's finding noted above.
- County Weaknesses: The Department would concur with the agency's finding of concern noted above.
- Statutory and Regulatory Areas of Non-Compliance: There is no finding of regulatory non-compliance.

Department of Public Welfare Recommendations:

The Department agrees with the county recommendations noted above. Improved education to emergency room and non-specialty treatment medical professionals would be a statewide recommendation.

In consideration to the recommendation set forth by the local review team regarding the custody of a deceased child's medical rights and organ harvesting, this reviewer would heavily recommend statewide research and communication around this issue. This is an issue that will likely surface again and support to the county teams would be very beneficial.