

Office of Children, Youth and Families

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REPORT ON THE FATALITY OF

Heath Ryder

**DOB: 09/10/2009
DOD: 08/02/2010**

FAMILY KNOWN TO:

The family was not known to Franklin County Children and Youth

REPORT DATED 12/2/2010

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. Section 6349 (b)).

Reason for Review

Senate Bill No. 1147 now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date. This Act amends the Child Protective Services Law (CPSL) and sets the standards for reviewing and reporting child fatality and near child fatalities that were suspected to have occurred die to child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Heath Ryder	Victim child	09/10/2009
[REDACTED]	Father	[REDACTED] 1970
[REDACTED]	Mother	[REDACTED] 1976
[REDACTED]	[REDACTED] brother	[REDACTED] 2007
[REDACTED]	[REDACTED] half brother	[REDACTED] 2000

Notification of Fatality/Near Fatality:

This case was originally assigned to CYS [REDACTED] on 7/29/10 as it was unclear if the injury was accidental or abusive. The case [REDACTED] on 7/30/10 when [REDACTED] determined the child's injuries were not accidental.

Documentation Reviewed and Individuals Interviewed:

Central Region Office of Children Youth and Families interviewed the Franklin County Children and Youth (C&Y) [REDACTED] and reviewed the County Child Fatality report, case documents, medical records and case notes

Previous CY Involvement:

None

Circumstances of Child's Fatality:

On 07/29/2010 [REDACTED], mother of Heath Ryder, dropped him off at the home of unlicensed babysitter, [REDACTED] at approximately 6:05 am. At that time Heath did not appear to have any medical concerns. He was given a bottle by [REDACTED] immediately upon arrival. Heath ate lunch and at approximately 1:30 pm Heath was laid down for a nap. At 2:50 pm, [REDACTED] attempted to wake Heath, who was breathing, but was unresponsive. [REDACTED] contacted

██████████ by phone and asked if she ever experienced Heath not awaking from his sleep. ██████████ said she had not but informed ██████████ she was on her way to pick Heath up. ██████████ arrived at ██████████ home within a few minutes. ██████████ met ██████████ at the door and handed Heath to her. ██████████ was hysterical and immediately called 911. ██████████ had asked ██████████ to call 911 during the two phone conversations prior to her arrival but was always told that Heath was okay.

Paramedics arrived at the home of ██████████ and transported Heath and ██████████ to Chambersburg Hospital. ██████████ saw the child in the emergency room and a CAT scan was performed. The CAT scan revealed ██████████. ██████████ Heath was then flown via helicopter to Hershey Medical Center. ██████████

██████████. The child remained on life support until 9:10 am on 08/02/2010 when it was determined there was no brain activity. Medical staff ceased support and the child was pronounced dead.

The initial focus of the investigation centered on ██████████. The other two children were removed from the home and were placed by voluntary consent of the parents with family members. ██████████ were interviewed by Pennsylvania State Police (PSP) Chambersburg along with Franklin County Children C&Y staff. All 3 passed their initial polygraph tests.

██████████, medical staff at Hershey Medical Center, determined that the physical trauma occurred possibly within 2 to 3 hours but no more than 6 hours prior to him becoming unresponsive. This medical determination places the time of injury between 10:00 am and 4:00 pm. The child had been in the care of the babysitter, ██████████, since 6:00 am on the date of incident.

██████████ was re-interviewed by PSP and admitted that as she was walking down the stairs holding Heath and Heath's head may have hit the wall.

Current/Most Recent Status of Case:

██████████ were advised to contact the agency if they needed any support, and information was shared with respect to ██████████. Since ██████████ is not a licensed child care provider, the case was referred to Department of Public Welfare, Central Region Office of Child Development and Early Learning. Although their report is not finalized, the office will not be taking any action toward ██████████ since they were informed that she is no longer providing child care in her home. They would have sent a cease and desist letter explaining that she should have no more than three children in her home at any time as a unregistered provider.

PSP Chambersburg is awaiting approval from the District Attorney to file charges against ██████████. The District Attorney is attempting to speak with ██████████.

Hershey Medical Center, to verify the injuries and time frame before formal charges are filed.

Services to Children and Families:

Franklin County Children and Youth provided guidance and support to the [REDACTED] family throughout the course of the investigation. On 07/30/2010 the agency initiated a safety plan calling for supervised contact between the parents and the other children while the children remained with relatives. [REDACTED] passed her initial polygraph test and based on all available information, [REDACTED]. On 08/03/2010, C&Y learned, via the coroner's office, that medical staff at Hershey Medical Center had diagnosed Heath with retinal folds. Hershey was able to ascertain that the injuries occurred within 6 hours of his unresponsiveness, placing Heath at [REDACTED] at the time of the incident. On 08/04/2010, the agency instructed [REDACTED] that she was not allowed to baby-sit any children. On 08/05/2010 and 08/17/2010, C&Y made an unannounced visit to the [REDACTED] residence. There were no children in the home. On 08/25 and 08/26/2010 the agency attempted unannounced visits to the home but there were no cars or activity could be heard within the home. No one answered the door. On 08/06/2010, after an administrative staffing and concurrence from law enforcement, the parent's safety plan was lifted and the children were returned home as the focus of the investigation was [REDACTED].

County Strengths and Deficiencies as identified by the County's Fatality Report:

Strengths-

A Child Fatality review occurred on August 16, 2010 and included participants from PSP, District Attorney's office, Coroner, Chambersburg Hospital, JPO and Franklin Co. Human Services

There was a general cooperation between C&Y and law enforcement. Franklin County C&Y has a well established rapport with Chambersburg Hospital and Hershey Medical Center. PSP are aggressively investigating this case. They have assigned sufficient manpower and have included the support of the District Attorney's office. Franklin County C&Y along with Nurse Family Partnership and others continue to educate the community with respect to child abuse identification and prevention.

Deficiencies-

There was some confusion and resentment on the part of law enforcement with respect to the necessity for involvement from Franklin County C&Y. The review team was not privy to all of the specifics of the PSP investigation. Because the criminal investigation was on-going at the time the team was convened, the

attendees indicated a certain frustration at being required to review the case at such an early stage.

County Recommendations for changes at the Local and State Levels as identified by Fatality Report:

The team would like to see an organized education outreach to parents regarding use of licensed vs. unlicensed daycare providers and the need for more funding at the state and local levels which would be available to families for retention of approved daycare providers.

The team identified the need for preventative training [REDACTED] to families and children. Specifically, educating parents how to recognize abnormal symptoms or behavior in children and when it's appropriate to call 911. There is a need for available parenting classes.

The team identified schools as a valuable resource for educating teens on issues [REDACTED].

Central Region Findings:

County Strengths-

- Franklin County C&Y conducted a thorough investigation [REDACTED]
- The agency assessed safety and assured safety of the remaining two children. The agency conducted home visits on 07/30/2010 and 08/02/2010.
- The agency coordinated and cooperated with law enforcement.
- The agency obtained medical information.

Deficiencies-

No deficiencies noted.

Statutory and Regulatory Compliance Issues:

- Franklin County C&Y conducted an appropriate investigation [REDACTED]
- The [REDACTED] interviewed the parents, babysitter, and medical staff from Chambersburg and Hershey Medical Center.
- A safety assessment was completed on 07/30/2010. The [REDACTED] met with the parents and assured the safety of the two remaining children.
- A risk assessment was completed on 09/24/2010. Overall risk is none as there are no allegations [REDACTED] for the two remaining children.
- The family remained open for services until 09/28/2010. The family was referred for [REDACTED] to deal with the loss of Heath.