



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Dominic Neumeyer

Date of Birth: October 31, 2009

Date of Death: October 29, 2012

Date of Oral Report: November 7, 2012

FAMILY KNOWN TO:

Beaver County Children and Youth Services

REPORT FINALIZED ON: 10/31/13

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. Beaver 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>
Dominic Neumeyer	Victim Child	10/31/09
[REDACTED]	Mother	[REDACTED] 91
[REDACTED]	Father	Unknown
[REDACTED]	Mother's Paramour	[REDACTED] 87

Notification of Child Fatality:

On October 29, 2012 Beaver County Children and Youth Services received a report regarding a 3 year old child who was admitted to the [REDACTED] emergency department after reportedly falling from a dresser while in the care of his mother's paramour. The report documented that the child had suffered [REDACTED] and he was not expected to survive the injuries. On November 3, 2012 the child was removed from life sustaining support systems and pronounced dead. Afterwards, the child was given a full examination and found to have [REDACTED] No damage to the child's [REDACTED] was noted. Due to the findings, a fatality report [REDACTED] on November 7, 2012 based on the physician's belief that the injuries were a result of [REDACTED] It was reported that the injuries were not consistent with the explanation given by the paramour.

Summary of DPW Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed the [REDACTED] intake record pertaining to the fatality investigation. Interviews occurred from the intake and ongoing workers. Updated case notes were reviewed via Western Region's access to the county's CAPS database.

The regional office also participated in the Beaver County local review meeting on November 30, 2012.

Children and Youth Involvement prior to Incident:

Beaver County had no prior involvement with the victim child or his mother. Beaver County was however involved with [REDACTED] and his children during the months prior to the fatality.

On February 21, 2012 Beaver County Children and Youth received a referral regarding [REDACTED] his wife and his three boys. The family was living in New York State at the time of the referral. The father and his children were planning to move to Beaver County to live with the father's parents. A referral was made to assess the home in Beaver County and to provide courtesy supervision of the family while New York maintained jurisdiction. The case in New York was opened after an [REDACTED] on the three year old child who was [REDACTED] by his mother. The mother had been incarcerated after pleading guilty to charges related to the [REDACTED] of the three year old and the father was securing primary custody of the children.

Beaver County accepted the referral and opened the family for services on April 4, 2012. New York State closed jurisdiction and finalized all court orders in July 2012. Beaver County continued to provide services to the father and the children, including parenting support and supervision. The mother was released from prison in late July 2012 and moved to Beaver County to be closer to the children. All contact with the mother was approved and supervised by the County or the father.

The father began a relationship with the mother of the victim child of this report in early October 2012, just prior to the incident. The mother and the victim child moved into the father's home with him and his children approximately one week prior to the fatality.

Circumstances of Child Fatality and Related Case Activity:

On October 29, 2012 Beaver County Children and Youth Services received a report regarding the 3 year old victim child. The report indicated that the child was admitted to the [REDACTED] emergency department after reportedly falling from a dresser while in the care of his [REDACTED]

The agency's communication with the hospital documented that the child had suffered [REDACTED] and was not expected to survive the injuries. On November 3, 2012 the child was [REDACTED] and pronounced dead. Afterwards, the child was given a full examination and found to [REDACTED]. No damage to the child's [REDACTED] was noted. Due to the findings, a fatality report was [REDACTED] on November 7, 2012 based on the physician's belief that the injuries were a result of [REDACTED]. It was reported that the injuries were not consistent with the explanation given by [REDACTED].

[REDACTED]

[REDACTED]

Due to inconsistencies in the [REDACTED] statements, Beaver County Children and Youth filed an [REDACTED] determination to [REDACTED] on December 28, 2012. [REDACTED] Police Department officially charged [REDACTED] in relation to the death of the child on January 30, 2013. The charge was criminal homicide. At this time, [REDACTED] is incarcerated and still awaiting trial.

Current Case Status:

The victim child's mother was referred [REDACTED] and her case was closed.

The [REDACTED] case remains open with the agency, with parenting, [REDACTED] and visitation services provided to the children's mother. There are also [REDACTED] services being offered for the older child. At this time, the children remain in care with their grandmother.

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

- Strengths: The county report gave no listing of strengths in regards to the management of the case or the investigation.
- Deficiencies: The county report gave no listing of deficiencies in regards to the management of the case or the investigation.

Recommendations for Change at the Local Level: No recommendations given by the local team.

Recommendations for Change at the State Level: No recommendations given by the local team.

Department Review of County Internal Report:

The County reportedly submitted the report prior to the Department's review on June 28, 2013; however the Department was unable to locate the initial report submission. The County report gave an extensive summary of the facts associated with the investigation, however gave no finding of strengths, deficiencies or recommendations.

Department of Public Welfare Findings:

County Strengths: The Department recognizes that the agency conducted a thorough assessment and displayed positive collaboration with hospital and law enforcement staff. Significant interviews and correspondences took place during the investigation process. Adequate home visits were being made during the investigation, by both the investigating worker and the on-going worker. The on-going involvement of the family appeared to be supportive to the family needs and provided appropriate monitoring based on the identified needs of the family unit.

- County Weaknesses: The Department did not identify any county weaknesses regarding this assessment and the services provided to the family.
- Statutory and Regulatory Areas of Non-Compliance:
No findings of statutory and regulatory non-compliance.

Department of Public Welfare Recommendations:

Per Act 33, the local review team must submit a final written report on each child fatality or near fatality to DPW and designated county officials consistent with § 6340 (a) (11) of the CPSL within 90 days of convening. This report must include information pertaining to the following:

- Deficiencies and strengths in compliance with statutes, regulations and services to children and families;
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to child abuse and neglect;
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse and neglect.

The final report submitted to the Department contained details that fell under headings titled "Case Summary", however it would be recommended that future reports be all-inclusive to better identify the "deficiencies and strengths" as a whole in compliance with the statutes, regulations and services to the families. Additionally, the report failed to include recommendations, if any, for changes on the state and local levels on reducing the likelihood of future child fatalities/near fatalities related to child abuse, the monitoring of county agencies and on collaboration of community agencies/service providers to prevent child abuse. It would be the Department's recommendation that this information be added to the final reports.

The final report was prepared by the county caseworker. The draft bulletin indicates that the team may not be chaired by the county agency. It would be recommended that in future reports a community provider involved in the local review meeting be assigned to chair and prepare the final report.