



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Gracie Nicholson

BORN: December 28, 2010
DATE OF FATALITY: June 24, 2014
DATE OF ORAL REPORT: June 23, 2014

FAMILY WAS NOT KNOWN TO:

Westmoreland County Children's Bureau

REPORT FINALIZED ON:

March 16, 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, DHS 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. Westmoreland County has not convened a review team in accordance with Act 33 of 2008 related to this report since the County made an [REDACTED] determination within 30 days of the date of the oral report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Gracie Nicholson	Victim Child	12/28/10
[REDACTED]	Mother	[REDACTED]/88
[REDACTED]	Father	[REDACTED]/89
[REDACTED]	Sibling	[REDACTED]/12
* [REDACTED]	Sibling	[REDACTED]/15

* [REDACTED] was born after the victim child's death and is a member of the current household.

Notification of Child Fatality:

Westmoreland County Children's Bureau received a referral on June 23, 2014 that a 3 year old female child was admitted to the Children's Hospital [REDACTED] after she was found unresponsive tangled in a purse strap which was hanging from a hook on the back of the child's bedroom door. The mother reported the purse was cloth with a long strap and there had been a toddler chair near the door. The mother reported that the child and her 2 year old sibling were upstairs while the mother was downstairs. The examining physician noted that the child had ligature marks to the right side of her neck. The father was at work at the time and the child was home with her mother. The mother was reportedly "acting funny" and self-reported taking [REDACTED]. The local police detective was at the hospital and had reported allegations of the mother using crack-cocaine. The physician certified the child to be in critical condition and the report was [REDACTED].

Summary of DHS Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. There was no County Internal Fatality Review Team meeting held as the report was [REDACTED] within 30 days of the date of oral report.

Children and Youth Involvement prior to Incident:

Westmoreland County Children's Bureau had no prior history or involvement with this family. The family did have a history of services in Fayette County; however communication with Fayette County Children and Youth Services verified no history of involvement with the county child welfare system.

Circumstances of Child Fatality and Related Case Activity:

On June 23, 2014 Westmoreland County received a call from [REDACTED] [REDACTED] inquiring if a report had been received regarding a 3 year old child that had been admitted to the Children's Hospital [REDACTED] after she was found unresponsive hanging from a purse strap. About an hour and half later [REDACTED] called to discuss the case with the intake supervisor. It was reported that the mother had been downstairs when her children were playing upstairs. The child's condition was poor and she was not expected to survive. [REDACTED] made the call to ChildLine to have the report [REDACTED].

Immediate response was made to the hospital to see the child and gather additional information. While at the hospital, the worker met with [REDACTED] who reported that he had just attempted to speak with the father, however he was very upset and emotional and could not provide much information. The father reported that he had been at work and had left the house by 3:45am that morning. The father reported he was notified of the incident by the paternal grandfather and then came straight to the hospital. The father reported to [REDACTED] that there were no issues the previous night before the family went to bed and that had been his last interaction with the child. Father stated that his family was "very religious" and that they prayed every night. It was reported that the mother was [REDACTED] when she was pregnant with the child and the child had to be [REDACTED] [REDACTED] reported that the officers were at the family home and there was nothing out of the ordinary or of concern.

The worker and [REDACTED] conducted a joint interview with the mother, who also appeared very emotionally upset. She reported that the incident occurred about 12:00pm earlier that day. Both of her children were in the victim child's room playing with the door shut while the mother was down in the kitchen putting lunch in the crock pot. The mother reported that she heard what sounded like kicking. She went upstairs to check on the children but, before entering the room, she went to use the restroom first. Mother was questioned about a lock that was seen [REDACTED]. She stated that there was a lock on the outside of the child's door that was there at the time that they moved

into the home but it was not used. After using the restroom, the mother stated that she opened the door to the child's room and the sibling came out. When the victim child did not come out of the bedroom, the mother went in the room but did not see her right away. Then she looked behind the door and saw the child hanging from a hook that is about 3-6 inches off of the ground with her neck tangled in the strap of a purse. The mother reported that she had to move a "Little Tykes" play chair out of the way that appeared to have been knocked over. The mother assumed the child climb up on the chair and then the chair got tipped over. The mother reported that she was unable to get the child untangled so she took the entire purse off of the hook and ran outside with child. The mother stated that she attempted CPR and reported that the child was throwing up liquid. Since the mother did not have any paid minutes on her phone, a neighbor called 911. Mother stated that this was uncharacteristic of the child and that the mother took safety precautions throughout the house. The mother was asked about the younger sibling and the mother reported that he would be going home with the maternal grandparents temporarily.

Follow up was made with the maternal grandparents and a visit was made to their home to assess and ensure the safety of the sibling. Additionally, a home visit was made to the home where the incident occurred. The agency did a home assessment of the family home to assess for any possible safety concerns when the family lived there. The family ultimately moved out of the home and moved in with the maternal grandparents.

On June 24, 2014, the victim child passed away. Further review of the medical report suggested that the child could have died in a way presented by the mother. There were no prior reports of supervision concerns and the mother appeared to be [REDACTED]. The criminal investigation did not result in any criminal charges and the County submitted an [REDACTED] on July 22, 2014 as the incident was determined to be an unfortunate fatal accident. The case was closed at the intake level; however, community services [REDACTED] were recommended to the family.

Current Case Status:

The case was closed on July 22, 2014 when the county submitted the [REDACTED]. As of the date of this report, a secondary report was received on February 17, 2015 regarding the birth of their newborn. The child was born [REDACTED]. Although the child had to be [REDACTED], she was doing well. The child [REDACTED] the care of her parents and the investigation was closed after the assessment found no identified concerns or needs to be addressed.

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

Westmoreland County has not convened a review team in accordance with Act 33 of 2008 related to this report since the county submitted [REDACTED] within 30 days of the date of the oral report.

- Strengths: N/A
- Deficiencies: N/A
- Recommendations for Change at the Local Level: N/A
- Recommendations for Change at the State Level: N/A

Department Review of County Internal Report:

Westmoreland County has not convened a review team in accordance with Act 33 of 2008 related to this report since the county submitted an [REDACTED] within 30 days of the date of the oral report.

Department of Human Services Findings:

- County Strengths:
The response to the report was an overall strength. The response was immediate and thorough. Collateral contacts were extensive and coordination with the law enforcement department showed mutual respect in regards to information sharing and responsibility. The county appeared to engage the family in a manner that offered condolence as well as gathered sufficient details to complete the investigation.
- County Weaknesses:
No weaknesses were identified in regards to this report.
- Statutory and Regulatory Areas of Non-Compliance:
No statutory or regulatory areas of non-compliance were found.

Department of Human Services Recommendations:

There are no formal recommendations based on the report. The Department recognizes that this was an unfortunate and horrible accident that resulted in the death of a young child. Although the mother had a [REDACTED] and was presently [REDACTED], the county appeared to enter the investigation with an objective and professional attitude. The subject of the substance abuse was uncovered through the referral and addressed with the family, however was not immediately used in judgment against the mother.