



REPORT ON THE FATALITY OF:

Storie Kuhn

Date of Birth: 11/17/2014

Date of Death or Date of Incident: 09/08/2015

Date of Report to ChildLine: 09/08/2015

CWIS Referral ID: [REDACTED]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Mercer County Children and Youth Services

**REPORT FINALIZED ON:
April 18, 2016**

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. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Mercer County has not convened a review team in accordance with the Child Protective Services Law related to this report. The county review team did not conduct a review of this case due to the ChildLine report being [REDACTED] within thirty days of receiving the referral.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Storie Kuhn	Victim Child	11/14/2014
[REDACTED]	Biological Mother	[REDACTED] 1987
[REDACTED]	Biological Father	[REDACTED] 1982
[REDACTED]	Sister	[REDACTED] 2007
[REDACTED]	Brother	[REDACTED] 2009
[REDACTED]	Brother	[REDACTED] 2010
[REDACTED]	Sister	[REDACTED] 2013
[REDACTED]	Household Member	[REDACTED] 1989
[REDACTED]	Household Member	[REDACTED] 1982
[REDACTED]	Household Member	[REDACTED] 2009
[REDACTED]	Household Member	[REDACTED] 2010
[REDACTED]	Household Member	[REDACTED] 2012
[REDACTED]	Household Member	[REDACTED] 2013
[REDACTED]	Household Member	[REDACTED] 2015

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children, Youth and Family Services reviewed case records and conducted numerous follow-up phone calls with Mercer County Children and Youth Services (MCCYS) Director, Intake Supervisor and Caseworker.

Children and Youth Involvement prior to Incident:

The family did not have prior involvement with MCCYS. The family reported being involved with Clark County Children and Youth Services, Ohio, which was confirmed by MCCYS. The involvement was a result of a referral regarding the victim child

being [REDACTED]

[REDACTED] The case was closed with Clark County as of June 2015.

Circumstances of Child Fatality and Related Case Activity:

On 09/08/2015, MCCYS received a report stating the victim child had been found unresponsive at the family's current residence. The victim child had been laid down for a nap on an air mattress and approximately fifteen minutes later was found unresponsive by her father. The father initiated cardiopulmonary resuscitation and 911 was called. The family decided to drive the victim child to the Grove City Medical Center and while in route, met the ambulance. The victim child was then transported to Grove City Hospital by ambulance. [REDACTED]

[REDACTED] There was concern the victim child had a traumatic injury to the anus, [REDACTED] but it was unknown when this occurred. [REDACTED]

[REDACTED] It was later determined the opening in the rectal area was the result of the body's natural reaction to death. The medical staff could not, at that time, verify this injury was what caused the victim child's death. The [REDACTED] report listed this incident as non-accidental trauma that caused the death of the child.

MCCYS was in contact with [REDACTED] the night of the incident who reported that the medical professionals were waiting on the physical examination to clarify some things. [REDACTED]

[REDACTED] The autopsy report indicated the cause of death was Positional Asphyxia and ruled Sudden Infant Death Syndrome (SIDS). There was no evidence of sexual assault or signs of sexual abuse or trauma.

On the evening of the incident, all nine surviving children were placed in multiple foster homes and forensic interviews were scheduled for all of the children. The interviews were to take place the following day at Mercy Hospital in Pittsburgh, Pennsylvania. While the forensic interviews were taking place the results of the autopsy were made known to all parties. [REDACTED]

[REDACTED]

The parents reported that the family had recently moved from Clark County, Ohio and moved in with family friends. The household was a two family household with a total of four adults and ten children. The victim child's family was comprised of five children (victim child included) and the victim child's biological mother and father. The family was in need of their own housing. The family that owned the residence

was comprised of five children (four siblings and one step sibling) and their biological mother and father (father to the youngest child and step-father to the four siblings).

The family owning the residence was involved with MCCYS [REDACTED] [REDACTED] regarding their youngest child. The male homeowner was known to the agency as he was a Tier 3 Megan's Law Offender. MCCYS and the Pennsylvania State Police had been to the home prior to the 09/08/2015 incident and explained to all parties the children were not to be left unsupervised with the male homeowner due to his Megan's Law registration. All parties agreed to this plan. It was not reported if the home assessment was satisfactory regarding sleeping arrangements for all the parties living in the home.

Following the fatality, MCCYS completed home visits and observed the sleeping arrangements for all the remaining children. There were six beds for nine children. It was reported the victim child had been sleeping on an air mattress at the time of the incident. A two-year-old was sleeping in a pack n' play, another two-year-old was sleeping on a changing pad located on the floor and two boys were sharing a bed. There was a crib noted in case record documentation that was allegedly being used by the five-month-old. MCCYS did not address the reason the victim child was sleeping on the air mattress while completing the home visit as the incident was determined to be accidental. [REDACTED] reported the air mattress was visibly deflated. MCCYS did make referrals for age appropriate beds. Additionally, the agency made referrals for [REDACTED] program, homemakers, and the possibility of [REDACTED] as the mother reported the children were having a hard time dealing with the death of victim child. However, subsequent documentation indicates [REDACTED] was not followed through with by the family. The family was reportedly compliant with the [REDACTED] provider although there was no progress in securing the family their own residence. MCCYS [REDACTED] report on 10/07/2015 due to the coroner stating that the child's death was a result of Sudden Infant Death Syndrome.

The mother of the victim child, the homeowner mother, and the victim child's father had agreed to not allow male homeowner to be unsupervised with the children in the home who were not his biological children. The male homeowner also agreed to this arrangement. A [REDACTED] report was received on 12/10/2015 stating the male homeowner had admitted during a polygraph, an ongoing procedure as part of his conviction, that he had been alone with children. A [REDACTED] report was generated and three of the children in the family's home disclosed he had driven them to school, unsupervised, various times since the beginning of the school year. [REDACTED]

Additional information regarding the family was provided to MCCYS in December 2015. The family began to move to a home in Florida in mid-December 2015, which

later fell through. While cleaning the residence in Florida, the family was burning trash and the mother threw a bag of trash into the fire which contained an aerosol can. The can exploded and her six-year-old son received third degree burns on his arms and face. He remains in the hospital in Florida. MCCYS was in contact with the hospital in Florida. The family ultimately secured a residence in Edgecombe County, North Carolina. MCCYS made a referral to Edgecombe County and they have accepted the referral and will continue providing services to the family.



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

- Strengths in compliance with statutes, regulations and services to children and families; An internal report was not completed as the ChildLine referral was determined to be [REDACTED] as the fatality was ruled accidental.
- Deficiencies in compliance with statutes, regulations and services to children and families; An internal report was not completed as the ChildLine referral was determined to be [REDACTED] as the fatality was ruled accidental.
- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; An internal report was not completed as the ChildLine referral was determined to be [REDACTED] as the fatality was ruled accidental.
- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; An internal report was not completed as the ChildLine referral was determined to be [REDACTED] as the fatality was ruled accidental.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. An internal report was not completed as the ChildLine referral was determined to be [REDACTED] as the fatality was ruled accidental.

Department Review of County Internal Report:

An internal report was not completed as the ChildLine referral was determined to be [REDACTED] within 30 days and the fatality was ruled accidental.

Department of Human Services Findings:

- County Strengths: The County responded immediately to the referral and offered services to the family.

- County Weaknesses: Sleeping arrangements, while briefly documented, did not address the sleeping arrangement of the victim child prior to the incident or on the date of the incident.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. There were no statutory or regulatory areas of non-compliance by the county agency noted.

Department of Human Services Recommendations:

- It is recommended as a system issue to ensure all parties are aware of medical examination outcomes prior to making conclusions of possible trauma. In this case this caused confusion between all parties when their perceptions, due to a Megan's Law Offender being involved, led to assumptions about the cause of the victim child's injuries.
- It is recommended that the county agency assess, address and document all sleeping arrangements in the home at initial contact and when learning of new household members moving into the home. There was no clear documentation as to the sleeping arrangement of the ten children prior to the fatality. The victim child's death occurred from suffocation on an air mattress. It is still unclear how often she slept on an air mattress or where the victim child regularly slept. This was not documented prior to the incident nor after.
- It is recommended during home visits (announced/unannounced) the children be interviewed not only regarding their ongoing well-being but in this specific case if they were at any time left in the care of the Megan's Law Offender.
- As the case continued in ongoing services and the knowledge of the children being left unsupervised with the Megan's Law Offender was disclosed by the children and admitted to by the alleged perpetrator, a consultation with the county solicitor may have been warranted in order to petition for court supervision.
- It is recommended that the children, once engaged in completing forensic interviews, complete the process. Although the interviews were initiated based on inaccurate medical findings, the completion of the interviews may have allowed the children to disclose in a safe, non-threatening environment any concerns within the household and may have provided further insight and information as to the family's daily routines and their overall well-being.