pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Tristan Hurtt

Date of Birth: 07/15/2009
Date of Death: 07/05/2016
Date of Report to ChildLine: 07/06/2016
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Fayette County Children and Youth Services

REPORT FINALIZED ON:

01/17/2017

Office of Children, Youth, and Families, Western Regional Office
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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.

On 07/27/2016, Fayette County Children and Youth Services (FCCYS) convened a review team in accordance with the Child Protective Services Law related to this report.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Tristan Hurtt	Victim Child	07/15/2009
[redacted]	Half-Sister	[redacted]2005
	Paramour's Son	2010
	Paramour's Son	2012
	Victim Child's Father	1989
	Father's Paramour	1991
* [redacted]	Victim Child's Mother	1989

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:
As part of the review of this fatality, the Department participated in FCCYS' review meeting that took place on 07/27/2016, obtained a copy of the family's case record, and reviewed pertinent information in the record related to FCCYS' involvement with this family.

Children and Youth Involvement prior to Incident:
FCCYS has had extensive involvement with this family prior to this incident, beginning in July 2009.

According to FCCYS' case management system, the family was referred on 07/16/2009 due to the victim child's mother testing positive for marijuana at the time of the child's birth. FCCYS accepted the family for services and provided [redacted] to the family until closure on 07/02/2010.

On 05/18/2011, FCCYS received a second [redacted] referral on the family. The concerns in this report were that the mother had [redacted] including a past

suicide attempt [redacted] The father was using drugs in the home and "attempted to" overdose in the home. There were also concern about the victim child's living environment being unsafe, with holes in the floor that allowed you to see to the ground, unsecured register vents, the child had to have medical care at 8-months-old due to burns on his hand, and other housing issues reported. FCCYS completed an assessment and felt that the children's needs were being adequately met and there were no safety concerns. The referral was closed on 06/02/2011.

On 09/24/2011, a third [redacted] referral regarding the children was received. This referral involved the mother overdosing [redacted] By the time FCCYS responded to the report, the mother had already been [redacted] and was located residing with a relative. The mother admitted to being addicted to drugs and as a result, FCCYS determined that a safety plan was necessary and the family was accepted for service on 10/19/2011.

Over the next three years, FCCYS maintained the family as an open case and ensured various forms of services were provided, including [redacted] domestic violence, anger management, [redacted] parenting, and [redacted] services. Also over this three year period, the children were placed into foster care on three separate occasions (10/25/2011, 03/21/2012, and 06/05/2014). The most recent foster care placement was necessary due to [redacted] and the victim child in this report was found in the middle of a road with no supervision. [redacted]

From the time of closure on 10/31/2014 until this incident on 07/05/2016, FCCYS received no further reports on the family.

Circumstances of Child Fatality and Related Case Activity:

On 07/05/2016, FCCYS received a report that the victim child was found hanging inside his closet. At the time of the report, the Pennsylvania State Police (PSP) and Emergency Medical Services (EMS) had already responded to the home, however, EMS could not revive the child and he was pronounced dead. FCCYS was initially contacted due [redacted] concerns that the closet shelving that the victim child was found hanging from was "fragile" and wouldn't have supported the child's weight. There were also reported concerns about the conditions of the home. FCCYS dispatched an agency supervisor and caseworker to the scene.

Upon arriving on the scene, FCCYS staff was advised of [redacted] concerns about the closet and also that marijuana was found under the coffee table in the living room. The supervisor was also allowed to view and photograph the victim child. The victim child had ligature marks on his neck and his face was purple. The home was noted

to have dog feces on the floor however, FCCYS staff did not believe the home conditions would be considered unsafe.

[redacted] summarized the information they had obtained thus far to FCCYS staff. As per [redacted] the father, his cousin, and paternal uncle were playing video games in the living room while the children played in another room. The father's paramour was in their bedroom doing work for her job. She heard one of the children scream and went running into the bedroom where the children were playing and found the victim child hanging from the closet shelving by a velvet belt for a robe. She took the victim child down and started performing Cardiopulmonary Resuscitation (CPR) on him while the father called 911.

On this same day, the family members were interviewed [redacted] Although the assigned caseworker was not permitted to sit in on these interviews, [redacted] did provide her with information periodically and she was able to speak with the family members after [redacted] interviews.

According [redacted] and information relayed to the caseworker, the father, paternal uncle, and cousin were playing video games in the living room, which is right next to the bedroom where the victim child died. At some point during the day, the paternal uncle and cousin smoked marijuana on the porch of the home, which is why a small amount was found. The father's paramour had just returned home from work and was in her bedroom working for her job. The 6-year-old child in the home said that he and the victim child were playing a "shooting game" in the bedroom when the victim child asked him, "Do you want to see me die?" The 6-year-old said, "No" but the victim child reportedly tied the belt around his neck and then stepped off of a small filing cabinet in the closet. The paramour heard screams, which is when she went to the bedroom and found the victim child. Although there were initial concerns at the time of the initial phone call to the agency regarding the fragility of the closet shelving and whether it would have supported the weight of the victim child, [redacted] found that the shelf actually supported the weight of an adult when they pulled on it.

Due to the concerns for safety in the home, the agency safety planned with the family. The family decided to have the paramour's children stay with their maternal grandmother (then eventually their father). The victim child's sibling went with a family friend.

The next day, 07/06/2016, this case was registered as a fatality. [redacted] The victim child's autopsy also took place. The preliminary results of the autopsy found no significant findings pending a toxicology report.

Over the course of the investigation, forensic interviews of the surviving children took place, as did interviews of the father and his paramour. The children reported that they had been supervised "within the hour" by an adult in the home. The 6-

year-old child reported that he went to the father to report that the victim child "was making a funny face" and that the victim child's "face is purple." The father did not respond to the 6-year-old because he is Autistic and the day before, the victim child had gotten poison ivy on his face, so the father believed this is what was talking about. When the father did not get up, the 6-year-old child went to the 11-year-old, who was the one to find the victim child and screamed. The 11-year-old reported that the victim child played with the belt "all the time" trying to tie it to everything.

During the father's interview, he reported playing video games in the living room with paternal uncle and cousin while the children were playing in the bedroom. The father reported that paternal uncle and cousin "smoked a bowl" on the porch, but denied smoking any marijuana himself. His paramour returned from work and went straight to the bedroom without speaking to him, as they had been fighting over money. He recalls hearing her scream in a "terrifying voice" and "like she never has before" for him to respond to her "now!" When he went to her, he found her pulling the victim child down from the closet and he noticed the victim child's face and eye were purple. His cousin called 911 and he said he was "freaking out." He asked the 6-year-old what happened and the 6-year-old said the victim child asked him, "Do you want to see me die?" then climbed onto the filing cabinet and stepped off. The father reported seeing the victim child about 20 to 25 minutes prior to the incident. The father was drug tested and tested positive for marijuana and [redacted]

The paramour's interview was consistent with what was already reported. She did provide more information regarding the belt, saying the belt was not hanging in the closet prior to the incident and that the victim child often played with it, dragging it around tied to other toys. The paramour was drug tested and tested negative for any substances. Attempts to locate the paternal uncle and cousin for interviews were not successful.

It was learned on 08/11/2016 that the paramour's children, who had been staying with their father, would not be returning to her care.

On 08/22/2016, PSP contacted FCCYS to inform them that they were considering this incident a tragic accident and would not be pursuing criminal charges against anyone. On this same date, FCCYS came to the same conclusion as PSP and [redacted] the report [redacted] that resulted in the death of a child.

On 09/02/2016, FCCYS accepted the family for services as a [redacted] case to help improve parenting, ensure proper supervision is being provided, monitor the housing concerns, and address any substance abuse concerns that may still exist. The victim child's sister was returned to the father's care with the understanding that these services will remain in place until they are no longer deemed necessary.

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

The following strengths, deficiencies and recommendations were taken directly from the county's full internal report.

- Strengths in compliance with statutes, regulations and services to children and families;
  FCCYS was in compliance with all statutes and regulations. The initial response time was met. The Regional Office was notified verbally and in writing the following day. Immediate safety was assured by the caseworker hours after the report came in. All interviews were completed with pertinent members, forensic interviews were completed. CY 104 was sent to law enforcement, who were always included in interviews and to whom information was transferred to timely. Law enforcement did provide information when requested to agency. Act 33 requirements met including Fatality review team meeting prior to the 31st day.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  Deficiencies would include lack of a joint investigation between law enforcement and FCCYS. Children and parents having to be re-interviewed due to law enforcement's resistance to allow FCCYS in joint interviews is detrimental to the children and the overall disposition to a case. Collaboration was good in regards to information sharing but there were key points were joint interviews would have been beneficial for both agencies and the families. Law enforcement missed information from the Act 33 Fatality review meeting despite being invited. They also missed the forensic interview which they initially requested for the sibling children.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  No recommendations for change at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse in regards to this particular case.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  Again no recommendations for changes at the state and local levels on monitoring and inspection of county agencies in regards to this case.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  The only recommendation again would be to educate law enforcement (outside of Fayette County) on the benefits of joint interviews, utilizing Multidisciplinary Investigative Team (MDIT) approaches to investigations. More training and specialized law enforcement to handle joint investigations.

Department Review of County Internal Report:
The Department received FCCYS' full report on 10/22/2016, within the timeframe according to the Child Protective Services Law (CPSL). The Department found FCCYS' internal report to be complete and informative, as well as in compliance with the CPSL. The Western Region Office of Children, Youth and Families is in agreement with the findings of their internal report.

Department of Human Services Findings:
County Strengths:

- FCCYS responded immediately by sending a caseworker and supervisor to the residence. The workers observed the scene and gathered information to ensure safety of the other children in the home.
- Safety plans were developed with the family [redacted] to provide the family with an opportunity to have their position heard.
- The caseworker attempted to participate in or observe PSP's interviews of the caregivers. Although she was denied, they did provide her with a summary of the information they learned and allowed her to speak with them afterwards.
- FCCYS met all of the timeframes when investigating the incident.
- The FCCYS review meeting was coordinated well and had good attendance from multiple disciplines.
- FCCYS is cooperative and transparent with the Department.
- FCCYS ensured that supportive services were immediately put in place for the family.

County Weaknesses: and

- As noted by FCCYS, there wasn't really a collaborative investigation between FCCYS and PSP. Although the assigned caseworker went to the State Police barracks to participate or observe the interview, the investigating Trooper(s) denied the caseworker to be present. This is less of a weakness for the county, but more of a weakness for the MDIT approach to investigating these incidents. Having multiple interviews is not best practice for any investigation; it is also not in the best interest of children in abuse investigations and/or family members who have just experienced a significant loss.

Statutory and Regulatory Areas of Non-Compliance by the County Agency.

- FCCYS was in compliance with all laws and regulations during their involvement with this case.

Department of Human Services Recommendations:

- FCCYS should continue to respond in the same manner to incidents such as this or any other incident where child safety may be in jeopardy.

- FCCYS should also continue to follow the same process for a near fatality or fatality report, as it was well organized and in compliance with the CPSL.

- FCCYS may want to consider having a conversation with the District Attorney's office regarding the benefits of joint investigations and interviews. If there are concerns with any entity in the MDIT, those concerns should be frankly discussed so that the team can move forward for the sake of child safety and the integrity of investigations.