pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Jimmy Rhoderick

Date of Birth: 10/20/2016
Date of Death: 10/29/2016
Date of Report to ChildLine: 11/23/2016
CWIS Referral ID: [redacted]

FAMILY NOT 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:
05/01/2017

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.

Because Fayette County Children and Youth Services (FCCYS) completed their involvement with the family prior to the 30th day, the agency did not convene a review team, as they are not required to do so according the Child Protective Services Law.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Jimmy Rhoderick	Victim Child	10/20/2016
[redacted]	Sibling	[redacted]2012
[redacted]	Mother	[redacted]1985
[redacted]	Father (Deceased)	[redacted]1985
* [redacted]	Maternal Grandmother	[redacted]1963

* 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:

To compile this fatality report, the child's file was reviewed, as well as a collateral contact with FCCYS staff to help provide further clarification.

Children and Youth Involvement prior to Incident:

According to case records, FCCYS had no prior reports or involvement with this family.

Circumstances of Child Fatality and Related Case Activity:

FCCYS first became aware of this victim child's death while agency staff was participating in the County's regularly scheduled Department of Health Child Death Review Team Meeting. During the meeting held on 11/10/2016, the county coroner informed the agency staff that the victim child's death was not considered to be suspicious and was being ruled accidental or was the result of natural causes.

Because of these statements, abuse or neglect was not suspected so a report to ChildLine was not made regarding the death.

On 11/23/2016, the agency received a report [redacted] regarding the victim child's death. According to the report, there were concerns that [redacted] was abusing drugs and not appropriately caring for the surviving sibling properly. The report also stated [redacted] may have been "high" on marijuana or heroin and fell asleep when she was caring for the victim child, causing his death.

Immediately upon receiving this report, agency staff made a collateral phone call to the [redacted] barracks and the agency staff spoke with [redacted] confirmed that there was no suspicion of child abuse. [redacted] was adamant that she had no concerns for [redacted] behaviors surrounding the victim child's death. According to the case record, [redacted] was upset that [redacted] would have to be re-interviewed and relive the trauma.

With this information, the agency contacted ChildLine and attempted to get the report de-certified, as they did not agree that it should be registered as such. However, it was determined that the report was registered properly and the report remained a fatality.

FCCYS received this report on the Wednesday before Thanksgiving. Because they did not want to re-traumatize [redacted] family, the agency made a conscious decision not to make any contact with the family until the following Monday, 11/28/2016.

The agency began making attempts at contacting [redacted] and sibling on 11/28/2016. The agency made reasonable attempts to contact and locate [redacted], but were not able to do so until they made contact with the paternal grandmother, who passed a message onto [redacted] On 12/01/2016, the agency was finally able to meet with the mother and the sibling. This contact took place at the maternal grandmother's home, which is where [redacted] and sibling were residing.

According to [redacted], the victim child had woken up hungry in the middle of the night. [redacted] fed the subject child on the couch and fell asleep sitting upright, with the victim child on a "boppy pillow." The sibling was asleep on the other couch in the room and woke [redacted] up at 6:00 AM. When [redacted] woke up, she realized that the victim child was not breathing and stated she immediately ran to the maternal grandmother's bedroom with the victim child and called 911, however, she was too upset to talk to 911 so the maternal grandmother got on the phone. The 911 operator coached the maternal grandmother with performing cardiopulmonary resuscitation (CPR) until the ambulance arrived. [redacted] rode along in the ambulance with the victim child and remained at the hospital while the medical staff attempted to revive the child. However, [redacted] was informed that [redacted] child had passed away. PSP and the coroner went to [redacted] home that day and investigated the scenario.

The sibling was seen in the home on 12/01/2016 and there were no concerns for the sibling's care. The agency obtained releases of information from [redacted] the children's doctor, and the coroner.

During their contacts with [redacted] on 12/01/2016 and 12/05/2016, she admitted that she had been [redacted] since 2012, but denies using any other substances. [redacted] The caseworker drug tested [redacted] at both of these visits and she tested negative for all substances except [redacted]

The case record documents that on 12/14/2016, the agency contacted the Fayette County Coroner's office, who confirmed that the victim child's death was that of natural causes and there were no concerns for child abuse. FCCYS sent the releases of information to the providers that [redacted] and requested information on the family, [redacted]

Also on 12/14/2016, the agency closed their involvement with [redacted] as they determined that she was adequately meeting the needs of the surviving child [redacted]

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

Since the child's death was determined to be accidental and the agency completed their involvement with the family within 30 days, they were not required to convene a meeting to address these questions.

- Strengths in compliance with statutes, regulations and services to children and families;
- Deficiencies 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 abuse;
- 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.

Department Review of County Internal Report:

As stated above, there was no internal report completed since the death was accidental and the agency closed their involvement within 30 days.

Department of Human Services Findings:

- County Strengths:
  - Upon receiving the report from ChildLine on the Wednesday before Thanksgiving, the agency contacted professionals that had already assessed the situation and determined there were no concerns for abuse, i.e. the county coroner and the PSP. As such, the agency was sensitive to [redacted] grief and loss and chose not to contact [redacted] until after the Thanksgiving holiday.

    When the mother was contacted, the workers maintained their respect and empathy with the mother to minimize any re-traumatizing.

  - The agency made good collateral contacts to all professionals involved with the mother to help verify that the victim child's death was accidental and to gather information about [redacted], the children's physician, the hospital, etc.

  - The agency completed their involvement with the family in a timely manner, including two safety and risk assessments.

- County Weaknesses: and
  - The only area of weakness that was found was the agency sending out releases of information on the same day that they close the case. Should information come back from one of the providers that would cause the agency concern, they would be unable to address the issues because they cannot re-refer a case for that reason.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  The agency appears to have met all statutory and regulatory requirements during their involvement with this family.

Department of Human Services Recommendations:

There Department has no recommendations based on this report.