REPORT ON THE FATALITY OF:

Elizabeth Petrus

Date of Birth: 05/09/2013
Date of Death: 04/18/2016
Date of Report to ChildLine: 04/16/2016
CWIS Referral ID: ████

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

Armstrong County Children and Youth Services

REPORT FINALIZED ON:
12/05/2016

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))

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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.

Armstrong County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on July 12, 2016.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
[redacted]	Biological Mother	[redacted] 1985
[redacted]*	Biological Father	[redacted] 1979
[redacted]	Mother's Paramour	[redacted] 1979
[redacted]	Male Sibling	[redacted] 2010
[redacted]	Male Twin-Sibling	[redacted] 2013
Elizabeth Petrus	Victim Child	[redacted] 2013
[redacted]*	Maternal Niece	[redacted] 1982

* [redacted] is the children's biological father, has had no contact, and is not a household member.

Summary of OCYF Child Fatality Review Activities:

The Western Region Office of Children, Youth and Families obtained and reviewed all current records pertaining to the family as well as the victim child's autopsy report.

On 07/12/2016, the Western Region Office of Children Youth and Families attended the review team meeting, which was held within the 30-day regulatory statute. The review team included representatives from the Western Region OCYF, the District Attorney's Office, [redacted] Police Department, Armstrong County Coroner, Armstrong County Multidisciplinary Investigative Team Coordinator, an Armstrong County Children, Youth and Families intake and ongoing caseworker, a Casework Supervisor, and other members of the Multidisciplinary Investigative Team.

Children and Youth Involvement prior to Incident:

There was a prior investigation regarding the victim child's oldest brother on 08/09/2012. The victim child's older brother had handprint marks on his arms. It was alleged that his biological father grabbed him by the arms causing the handprint marks on his arms. The agency conducted an investigation into the report. The report [redacted] and the case was closed on 08/27/2012.

Circumstances of Child Fatality and Related Case Activity:

On 04/16/2016, the county agency received two [redacted] reports regarding the family. It was reported that the victim child, age 2, was in [redacted] at Children's Hospital of Pittsburgh (CHP) on life support. The report stated that the victim child was previously a healthy girl who underwent an unexpected and unexplained cardiac arrest. Since the reporting source was not the physician, this report was not registered as a near fatality initially it was registered as suspected child abuse for causing bodily injury. The other [redacted] report stated that the victim child's brother, age 6, had significant bruising on his buttocks.

An on-call caseworker went to the home of the maternal niece, to see the victim child's two siblings. The maternal niece reported she picked up the victim child and her twin brother from their home in the afternoon/evening of 04/15/2016 between 1:00 PM and 2:00 PM. She reported stopping at [redacted] to get milkshakes for the children and then going home. The maternal niece noticed after getting home that the victim child's mouth was dry and her tongue was sticking to the roof of her mouth when she would try to talk. It was reported both children appeared very thirsty and kept asking her for water. After giving the children multiple drinks, the victim child's twin brother went outside to play, however the victim child did not want to go outside and kept crying. The maternal niece reported that the victim child was complaining about her tongue hurting and she noticed her tongue was covered in small bumps. The maternal niece texted the biological mother a photo of the victim child's tongue and asked what was wrong. She continued to give the victim child popsicles and drinks until they ate dinner between 6:30 PM and 7:30 PM. The victim child ate a little chicken and broccoli and was given a half tablespoon of Motrin because she was still complaining her tongue hurt. She then fell asleep on the couch.

The maternal niece said the victim child woke up vomiting and she threw up a few times and then fell back asleep again on the living room floor. The maternal niece then put the other children to bed and went back to the living room, approximately 10 minutes later, and she found the victim child unconscious and her lips were blue. The maternal niece called her own father and began to perform cardiopulmonary resuscitation and called 9-1-1. The maternal niece stated she tried to call the mother multiple times, but she was not answering her phone and when she did answer, the mother wanted to know why the maternal niece was calling from an

unknown number. The victim child was transported via ambulance to Armstrong Hospital and then transferred to CHP.

There was not an identified cause for the victim child's cardiac arrest.

Later on that day, it was reported to the agency that the victim child's oldest brother had bruising to his buttocks. After the required tests on the victim child were completed, she was pronounced dead on 04/18/2016 at 4:44 PM. The mother decided to donate the victim child's organs for transplants. The victim child's eyes, liver, kidneys, and partial pancreas were donated and were not available for the autopsy which was completed on 04/20/2016.

On 04/16/2016, it was reported to the agency that the victim child's oldest brother had bruising to his buttocks. the victim child's two brothers, they were to remain with the maternal niece the oldest brother had a forensic interview on 04/20/2016. He disclosed again that he was physically disciplined with multiple objects by both his mother and her paramour and that he would often drink from the toilet due to being thirsty all of the time. Both of the victim child's brothers had physical examinations completed at CHP's Child Advocacy Center (CAC). The victim child's twin brother did not have any injuries.

On 4/20/2016, there is case documentation that called ChildLine to have the report on the victim child made a child fatality report. was told by the ChildLine worker that the report would not be made a child death report until the agency obtained the autopsy report which confirmed that the child died as a result of abuse and/or neglect.

The boys were placed in foster care on that date.

On 06/15/2016, the report was due to their role in failing to supply the victim child with water. The report on the victim child became a child fatality report on 06/16/2016. The report on the victim child's oldest brother was for the injuries to his buttocks on 06/16/2016. The criminal investigation is ongoing.

The agency has opened a case on the family. The victim child's two brothers are The mother and her paramour were

with the recommendation

On 09/26/2016, a final autopsy was completed and it was determined the victim child died due to Bilateral Bronchopneumonia and Aspiration. Her death was ruled "natural", an amended CY-49 was completed and a status determination of was assigned to reflect the autopsy findings. No criminal charges were filed regarding the victim child's death due to the autopsy findings.

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;
  - There was excellent coordination among District Attorney's office, Coroner, law enforcement and child protection agencies.
  - The county's MDIT protocol was carefully followed.
  - The county's Child Fatality Review Team was convened on 07/12/2016. All necessary parties were present, prepared with notes and documents, and actively participated in discussion.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - There was confusion from the beginning with this child's case being certified as a near fatality/fatality. Despite county agency staff questioning the non-certification status, it remained registered solely as a report of suspected child abuse. It was explained to county agency staff that a physician did not certify the report as a near fatality. The report came into ChildLine through the automated self-service portal. Western Region's records however reflect that this youngster's case is to be treated as a "child fatality" as of 06/16/2016. This date is tied to the county agency's initial determination of which as explained herein was subsequently
  - The medical examiner's office took 4 ½ months to respond to the Armstrong County District Attorney and the Coroner's request for information and request to move the case forward. On 09/06/2016, the victim child's death certificate was finalized. remained named as responsible parties in the victim child's death until the certificate was finalized in September.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

- None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

    - None

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

    - None

Department Review of County Internal Report:

The fatality report was submitted timely and appears to accurately summarize the case documentation. The report clearly states the events that occurred during the investigation process.

Department of Human Services Findings:

- County Strengths:
    - Armstrong County Children Youth and Family Services (ACCYF) did have good collaboration with Law Enforcement during the investigation process.
    - ACCYF responded immediately to the referral and conducted a visit to the home of the family member who was caring for the children at the time of the incident. ACCYF was able to explore Kinship as a primary option for the children at the time of the initial report and the children were able to remain with Kin.
    - ACCYF did coordinate with CHP for the biological mother and both siblings to have one last visitation with the victim child prior to removing her from life support.

- County Weaknesses: and
    - While Kinship was explored the dictation and documentation provided by ACCYF is unclear how the caregiver the maternal niece and any household members were ruled out as potential responsible parties in the victim child's fatality. The victim child was in her care at the time of the incident.
    - After request by the biological father to have visitation with his children, while awaiting assessment/approval of in person visitations by the caseworker/supervisor, encouraging some type of a communication plan (via mail, or phone) was not explored to allow the children to establish a relationship with their father. The supervised visit that occurred with the biological mother and paramour [redacted] occurred prior to one contact occurring between the children and their biological father.

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

  None

Department of Human Services Recommendations:

The Department needs to ensure that all of the employees of the Department are adhering to the requirements of the Child Fatality Bulletin. On 04/20/2016 there is case documentation that [redacted] called ChildLine to have the report on the victim child made a child fatality report. [redacted] was told by the ChildLine worker that the report would not be made a child death report until the agency obtained the autopsy report which confirmed that the child died as a result of abuse and/or neglect. The Child Fatality Bulletin permits anyone to report a child death.