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REPORT ON THE FATALITY OF:

Ryder Reinhardt

Date of Birth: February 8, 2011

Date of Fatality: May 15, 2011

**The family was known to
Westmoreland County Children's Bureau**

Date of Report: August 14, 2012

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, DPW 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 Children's Bureau convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Ryder Reinhardt	Victim Child	02/08/ 2011
[REDACTED]	Mother	[REDACTED] 1994
[REDACTED]	Father	[REDACTED] 1981
[REDACTED]	Twin Sibling	[REDACTED] /2011
[REDACTED]	Sibling	[REDACTED] 2007
[REDACTED]	Sibling	[REDACTED] 2005
[REDACTED]	Maternal Grandmother (Not living in the home)	Unknown

Notification of Child Near Fatality

On May 15, 2011, the Westmoreland County Children's Bureau on-call caseworker received a telephone call from Westmoreland County 911 reporting that Delmont Police [REDACTED] wished to speak with her regarding a child fatality. Once contacted, the [REDACTED] reported that [REDACTED] had just responded to a 911 call reporting that a 2½-month old baby had been found dead in his parent's home. The [REDACTED] requested that the caseworker meet [REDACTED] [REDACTED], Pennsylvania where the mother and victim child were being taken.

Upon arrival at the hospital, the on-call caseworker met with the Delmont Police [REDACTED], county detectives, officials from the District Attorney's Office, the mother and the maternal grandmother. Law enforcement officials reported that the mother called 911 after she found her son non-responsive while being held in the father's arms. The Delmont Police [REDACTED] and paramedics responded to the call and transported the child to the [REDACTED] where the child was pronounced dead at 10:47 am. Law enforcement officials reported that the child had no visible signs of trauma; however, it was reported that the father had been drinking heavily the night prior to his son's death.

Summary of DPW Child Fatality Review Activities

The Western Region Office of Children, Youth and Family Services reviewed the case file provided by Westmoreland County Children's Bureau for the May 15, 2011 intake referral and all past referrals. The file included the referral and demographic information, safety assessments, risk assessments, family service plan, on-going dictation, and other correspondence. The assigned Western Regional Program Representative began ongoing communication with the caseworker on May 16, 2011, and continued to maintain ongoing contact with the county agency. The Department attended the internal review conducted by Westmoreland County on June 8, 2011.

Summary of Services to Family

Children and Youth Involvement Prior to Incident

May 14, 2009 - Westmoreland County Children's Bureau received a [REDACTED] referral. The Delmont Police Department was dispatched to the family's residence at 1:40 am due to the father being out of control. The parents had recently separated and the father arrived at the home and kicked in the mother's front door. The father tipped over the refrigerator, the children's beds and the television. He sliced the furniture with a sharp object and was observed to be intoxicated. The father placed his children, [REDACTED], at risk. The father was removed from the premises by law enforcement and hospitalized due to him [REDACTED]. This referral was accepted for investigation.

June 30, 2009 - Westmoreland County Children's Bureau concluded the investigation of the allegations that were received on May 14, 2009. The mother obtained a PFA against the father. The father moved into his mother's residence and the mother maintained her private residence with the children. The maternal grandmother assisted the mother in babysitting the children whenever she attended work. The case was closed at intake.

February 9, 2011 - The Westmoreland County Children's Bureau received a referral that the mother had given birth to twins, [REDACTED] on February 8, 2011. The mother admitted to having no pre-natal care. She self-reported that she had given birth the year prior and had given that child up for adoption. She claimed that she did not intend to keep this child, but made the decision to keep this child too late to receive pre-natal care. The mother denied having knowledge that she was having twins. The hospital staff reported that the mother was very appropriate and loving to the children. The agency made the determination to screen out the referral.

Circumstances of Child Fatality

The mother explained that on May 14, 2011, around 10:00 pm, she and her friend decided to go to a local bar and she left all four of her children in the care of their father, [REDACTED]

She returned home between midnight and 1:00 am. Upon entrance to the home, the mother noticed that the father was awake on the couch and [REDACTED] and Ryder were asleep on the loveseat with their "boppy" pillow. The two older children, [REDACTED]; were upstairs asleep in the mother's bedroom. The mother retired for the evening and went to sleep with the older children.

In the middle of the night, the mother heard [REDACTED] and Ryder crying in the living room and went to feed them. She could not confirm the exact time she fed the children for the local authorities. She commented that Ryder was unable to finish his bottle; however, [REDACTED] drank his entire bottle. After feeding the twins, she returned to sleep with the older children.

A few hours later, the mother heard [REDACTED] crying and went to him. She immediately noticed that Ryder was lying in the father's left arm all "cuddled up" and [REDACTED] remained on the love seat. When the mother retrieved Ryder from the sleeping father's arms, she felt the stiffness of Ryder's body. Knowing something was seriously wrong with Ryder, she ran to her neighbor's home to call 911. She could not utilize her own cell phone due to not charging the phone battery. The mother then returned to the house to wait for the paramedics.

The mother, [REDACTED] and Ryder were transported via ambulance to [REDACTED], Pennsylvania. The father remained at the family residence with [REDACTED]

A safety plan was discussed and agreed upon by the mother and maternal grandmother. The safety plan was written and signed while the mother and grandmother were at the hospital. The established safety plan placed the children into the maternal grandmother's temporary care until the completion of the investigation. The maternal grandmother also agreed to supervise all contact between the parents and the children. Emergency clearances and a walk through of the maternal grandmother's home were conducted to ensure the safety of the children.

The county caseworker, county detectives and the Delmont Police [REDACTED] returned to the family's residence. As they arrived, the father was being taken from the home by paramedics. Reportedly, the father had passed out on the parent's bed and [REDACTED] were running around the home. A total of 17 empty beer cans were found throughout the home. The father admitted to drinking six to seven beers the morning of May 15, 2011 and doubling up on his [REDACTED] medication. Food, clothes and dirty diapers were found throughout the home.

The father was transported to [REDACTED] and was admitted. The father's blood alcohol level was determined to be 0.213.

After interviewing the neighbors, it was determined that the father and the neighbor had each purchased a 48 oz beer at 7:30 pm on the evening of May 14, 2011. The neighbor claimed that the father only drank approximately 18 oz. of his beer. The neighbor saw the father at 9:30 pm that evening and he did not appear to be visibly intoxicated.

However, once the police arrived at the home, the 48 oz. beer bottle was found in the kitchen sink empty.

The physicians at [REDACTED] reported that Ryder's death was presumably caused by [REDACTED]. The mother explained that Ryder had a runny nose a few days prior, but did not exhibit any other signs.

On May 23, 2011, the preliminary autopsy report stated it was determined that Ryder died from congestion in his lungs and pneumonia.

Based on the report by Delmont Police Department, a [REDACTED] investigation was initiated by the agency with the father being named as [REDACTED]. That investigation was concluded on June 27, 2011 with the status of [REDACTED].

During the course of the [REDACTED] investigation, the mother denied any [REDACTED] issues. She reported that the father was [REDACTED]. She denied any domestic violence until the maternal grandmother confirmed the mother and father had a volatile history. The mother then admitted to past domestic violence. The mother denied a criminal history. The father, however, had been incarcerated in the past, his history is detailed below:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Current Case Status

A revised safety plan was instituted on June 10, 2011, allowing the mother to have unsupervised contact with her children. This plan was discussed and signed by the parents. The safety plan also illustrated that the mother was responsible for ensuring that the father did not have any unsupervised contact with the children.

On June 27, 2011, the case was accepted for ongoing services and assigned to an ongoing caseworker. Both parents were requested to participate in parenting instruction, [REDACTED], and the father was asked to participate in [REDACTED].

