



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Jordan Kauffman

BORN: 06/15/2010
Date of Death: 01/28/2011

Report Dated: 5/25/2012

The family was known to Perry County Children and Youth Services

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 No. 1147, Printer's Number 2159 was signed into law 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 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. Perry County has 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> |
|-----------------|----------------------------|----------------------|
| Jordan Kauffman | Victim Child | 06/15/10 |
| [REDACTED] | Mother | [REDACTED]/91 |
| [REDACTED] | Father victim child | [REDACTED]/89 |
| [REDACTED] | Sibling | [REDACTED]/09 |
| [REDACTED] | Maternal Grandfather | [REDACTED]/40 |
| * [REDACTED] | Maternal Great Grandmother | [REDACTED]/43 |
| * [REDACTED] | Maternal Grandmother | [REDACTED]/71 |

([REDACTED] was not a household member; she became the resource for the sibling after the incident.)
 ([REDACTED] is referenced in this report in the previous children and youth involvement section.)
 ([REDACTED] is the father of sibling; he was not involved with the agency or circumstances of this report

Notification of Fatality:

On 1/28/11 emergency medical technicians (EMTs) responded to an emergency (911) call at the home of [REDACTED]. Upon arrival, the victim child, Jordan Kauffman, was [REDACTED]. The child was transported by ambulance to Carlisle Regional Hospital. The child was officially pronounced dead at the hospital. [REDACTED] to report concerns regarding the circumstances of the victim child's death. [REDACTED] contacted Perry County Children and Youth Services on 1/28/11 regarding the death of the child. The county agency caseworker followed up on the referral immediately and went to the victim child's home. The victim child's sibling was reported to be residing in the family home. The caseworker determined that the victim child's parents were at the hospital and the sibling was in the home with her maternal grandfather. The county agency assured the child's safety and a safety plan was implemented. The plan initially had the grandfather assuring no unsupervised contact with the mother and the father. The plan would be revised on 1/31/11 the

surviving sibling would reside with the maternal great grandmother who would provide supervision of the child during the [REDACTED]. This report [REDACTED]. It was assigned to a caseworker as an [REDACTED] referral.

After further discussion [REDACTED] on 1/31/11 regarding details and circumstances of the child's condition at the time of his death, Perry County Children and Youth Services determined that this report should be registered with [REDACTED]. The report was registered on 1/31/11.

It was also reported by [REDACTED] to Perry County CYS that the victim child had been treated for a [REDACTED] prior to the incident causing his death. It was then discovered that the child's other arm had previously been [REDACTED] also. The child had received no treatment for this injury. The child presented as [REDACTED] upon arrival at the hospital on 1/28/11. The victim child was seven months old and weighted 12.5 pounds.

Documents Reviewed and Individuals Interviewed:

The Central Region Office of Children, Youth and Families obtained and reviewed all current case records as well as all records from previous agency referrals pertaining to this family. Interviews were conducted with the agency caseworker [REDACTED], supervisor [REDACTED], and the Agency Administrator, [REDACTED] on 1/31/11, 2/11/11, 2/16/11, 3/17/11. The regional office participated in the County's Internal Fatality Review Team meetings on 2/16/11 and 3/17/11.

Summary of Services to Family:

Previous Children and Youth Involvement:

The agency received a total of six [REDACTED] for this family between February, 2009 and October 2010. On 2/17/09 the county received the first [REDACTED] which alleged the victim child's mother was smoking marijuana with friends while the victim child's sibling (who was three weeks old at the time), was present. The county agency accepted the [REDACTED] for assessment. The county caseworker conducted an unannounced home visit within the response time assigned and the worker addressed the concerns with the mother. Safety of the child was assessed. The mother admitted to using marijuana but denied doing so around her child. The mother informed the agency worker that if she chooses to do something of this nature, she takes the child to be cared for by her mother (victim child's maternal grandmother). At the time of the report the victim child's mother was living with her mother (maternal grandmother). Her mother was helping her care for her baby. Since the mother was living with her mother and her mother verified she was helping her daughter raise the child, the agency did not open the family for ongoing services. The case record had a name referenced for the child's father however his whereabouts was unknown to the

agency. He was later found to be incarcerated so his involvement with agency was limited.

On 11/25/09, the county agency received a second [REDACTED] which alleged the mother was smoking crack cocaine in the home while her child was present. The report was assessed and closed by the agency. [REDACTED]. When the agency caseworker went to the home unannounced on 12/2/09, the maternal grandmother answered the door and requested that the caseworker leave and come back the following day since the family had company. The caseworker went to the home the next day and no one answered the door. The case record documented an attempted home visit on 12/15/09. The maternal grandmother answered the door and stated the mother and child were upstairs sleeping and the caseworker would have to come back tomorrow. [REDACTED].

The maternal grandmother stated that the mother was no longer hanging out with the individual that caused [REDACTED] concern and agency services were no longer needed. The agency worker was not able to see the child and the mother until 12/16/09.

The child appeared healthy, dressed appropriately, clean, and did not present any concerns of being [REDACTED]. The agency caseworker addressed concerns regarding drug usage with the mother. The mother admitted to smoking crack previously but she no longer is hanging out with the person she used with. She stated that she was no longer using crack and denied that her child was ever present when she did so. The caseworker asked if she would be willing to submit to a drug test and she agreed. The result of the test was negative for all drugs. During the home visit the mother mentioned that she may be pregnant. [REDACTED]. She informed the caseworker that she will be going to the doctor for [REDACTED] in January. The caseworker informed the mother that using drugs during pregnancy created significant health risks to the unborn child. The mother was also made aware that hospital may test a newborn baby for drugs at birth. If the baby would test positive, it would most likely result in children and youth services becoming involved with her family. The family was asked if they needed any community or agency services. The family declined. The agency considered the case closed and did not open the family for ongoing services.

On 2/5/10 children and youth services received a third [REDACTED] pertaining to the mother using drugs and alcohol while she was pregnant and in the presence of her daughter. [REDACTED]. The report was screened out by the agency. The county agency did not conduct a home visit. The mother had left the home of the maternal grandmother for a period of time with her child and her exact whereabouts were unknown. In a follow up phone discussion with the maternal grandmother, the mother and child had returned to the home of the maternal grandmother. The maternal

grandmother informed the county worker that she intended to obtain custody of her grandchild.

The county agency received a fourth referral regarding the family on 7/5/10. The victim child of this report had been born and was in the home. The referral alleged the mother was using drugs every day. The report alleged concerns regarding the condition of the home and that the mother yells at her two children. The referral source also mentioned that the mother owed people money for drugs and was concerned for the family's safety. The county agency attempted to contact the family that day via an unannounced home visit. However, no one appeared to be at the home and no one answered the door. The caseworker made attempts that day to contact the mother, but her phone was disconnected. The worker contacted the maternal grandmother to inquire about how to contact the mother. The maternal grandmother verified that the mother was not living with her and provided the agency an address. On July 7, 2010 the agency caseworker conducted an unannounced home visit to the address provided. The parents at first were unwilling to answer the door however; the victim child's father eventually did open the door and let the caseworker see the two children and the home conditions. The children were determined to be healthy. There were no issues with the conditions of the home and there was food in the home for the children. The county agency completed a safety assessment on the two children and determined them to be safe. The agency worker addressed concerns regarding drug use. No drugs or drug paraphernalia were found in the home. The parents did not appear to be under the influence of any drugs or alcohol. The parents informed the agency worker that if they chose to participate in that type of activity they would arrange to have family members watch their two children. The family did not request any services from the agency. The agency did not open the family for ongoing services. [REDACTED]

The agency received a fifth [REDACTED] on 9/2/10. The [REDACTED] alleged that the mother was placing the victim child in the closet to sleep and feeding him baby food (which was a concern due to the child's young age). The reporting source mentioned that the victim child's sibling needs some type of [REDACTED] which the mother has not scheduled. The agency went to the home the same day as the report was received. The county caseworker was able to see both children and talk with the parents regarding the allegations. The caseworker was shown where Jordan sleeps. The caseworker observed the child in his bassinet sleeping. The area that the child was sleeping in was an extension of the bedroom where the mother and father slept. During the discussion, the caseworker asked the mother what she feeds the victim child. Her reply was that he is feed six ounces of formula every six hours. The victim child's mother did mention she tried to give the child cereal one time. The caseworker informed the mother that the child was too young for that. She understood and stated that she had only done that on one occasion. The caseworker provided counsel as to available services which may be of assistance to her. The victim child's mother

was informed about the family center in the community and the services they could provide. The mother informed the worker she would have to think about it. The caseworker then inquired about the older child's physical health. The mother explained that she has [REDACTED] but has been having a hard time scheduling her to be seen. She attributed some of this difficulty to the fact that she needs to bring the child's prior medical records to the appointment and her mother has them. The caseworker offered to assist her in obtaining these and requested that she sign medical releases which she did. The county worker was able to help assist the mother in scheduling the sibling to be seen at Hershey Medical center (HMC) [REDACTED]. The case record did indicate the child was seen at HMC [REDACTED] on 9/10/10. The agency made a referral to the family center for the mother, and it appeared she was interested in attending. The agency decided to close the [REDACTED] on 10/14/10 as it appeared the mother was able to provide the care for her children and was not in need of any further agency services.

On 10/28/10, the agency received a sixth report stating that the children's mother was in her home with friends snorting oxycotin and smoking marijuana at 3 am with her children sleeping in the home. The agency screened out this referral due to the time of the alleged incident and the fact that the victim child's father was not participating in the activity and was in the home to care for the children. The report did not mention any specific maltreatment occurring towards the children in the home. This was the last referral the agency received regarding the family prior to notification of the child fatality report received on 1/28/11.

Circumstances of Child's Fatality:

On Friday afternoon (1/28/11) both parents were in the home with their two children. The parents and children were living in the home of the maternal grandfather, [REDACTED]. The victim child's father and the victim child's sibling came out of the bedroom and went to the kitchen area of the home. The victim child and the mother remained in the bedroom. Shortly after leaving the bedroom, the victim child's father heard the mother screaming. She came out of the room stating that the victim child was not [REDACTED]. The father called 911 and family members tried to resuscitate the child with the guidance of the emergency dispatch worker over the phone. The ambulance arrived at the home, and the child was rushed to the Carlisle Hospital. The attempts to resuscitate the child by family members and then paramedics were unsuccessful. The child was officially pronounced dead at the hospital at 4:59 pm. The mother reported she last heard the victim child cry around 3:00 pm that afternoon. The parents also reported that the victim child was [REDACTED]. Medical records received confirmed that the victim child did not receive medical treatment for the symptoms described.

The parents were living in the home of the maternal grandfather at the time the fatality occurred. Upon investigation by law enforcement and the county children and youth agency, it was discovered that the make up of the home had two living areas so even though the parents were living with a maternal grandfather in his home, the maternal grandfather did not have frequent interactions with the parents or the children.

The victim child had been scheduled to be seen on 1/27/11 at [REDACTED] with the child's primary care physician but the appointment was not kept. The mother reported that the appointment was missed due to weather concerns. This was a follow up from a 12/28/10 check up in which the child was determined to have issues of [REDACTED]. The medical records reviewed stated that the child had been diagnosed as [REDACTED]. The medical staff did not make a report to the county agency or ChildLine regarding concerns with the child's condition after seeing the child on 12/18/10. The child was seen at an emergency room in Harrisburg on 1/08/11 due to the victim child not being able to move his left arm and appearing to be fussy when that area was disturbed. The child had x rays of both [REDACTED]. The child was determined to have a [REDACTED]. The parents informed medical staff that the child's sibling was jumping in the crib while the victim child was in the crib and landed on his arm. The parents were shown how to place the arm in a sling and instructed to keep the arm in that position at all times. The child was also [REDACTED]. The victim child was seen at the [REDACTED] in Harrisburg for two follow up appointments on 1/13/11 and 1/20/11. The medical facility did not report any concerns to the county children and youth agency or ChildLine regarding the [REDACTED].

An autopsy was completed on the victim child on 1/29/11. The exact cause of death listed on the report is [REDACTED]. However, medical records from Carlisle Hospital on 1/28/11 indicate the reason for treatment was due to the victim child being in [REDACTED]. The examination of the child's body did detect prior injuries. The victim child had [REDACTED]. The family did take the child to a Harrisburg Emergency Room for treatment. The victim child was seen at the [REDACTED], Harrisburg for a follow up appointment for the [REDACTED].

The parents informed medical staff that the victim child's sibling had jumped on him while he was in his crib. This explanation is concerning as the [REDACTED] to produce that type of injury. The x-rays of [REDACTED] were sent to Hershey Medical Center (HMC) and evaluated by the Director of Pediatric Orthopedics. The Director ruled out the possibility that the injury could have been caused by a 2 year old jumping on the victim child's [REDACTED]. The other [REDACTED] was never treated or

detected by medical staff; when the child was seen at the Harrisburg Emergency Room or during follow up treatment at the [REDACTED]. However, the testing and evaluation by HMC staff did determine that both [REDACTED] occurred around the same time since they had similar healing patterns and both were [REDACTED]. The HMC staff's review of the child's records also noted that the child had received [REDACTED]. It is possible that the [REDACTED] could have occurred as a result of attempts to resuscitate him. The victim child also appeared to be [REDACTED] upon arrival at Carlisle Hospital on 1/28/11. The victim child weighed only 12.5 pounds according to medical staff.

Upon receiving the initial report [REDACTED] on 1/28/11, the Perry County Children and Youth Services caseworker went to the home to observe the victim child's sibling and to assure her safety. The child was assessed, she had a full skeletal exam completed no injuries found. An [REDACTED] [REDACTED] was also completed. Due to the circumstances surrounding this case, a safety plan was developed in which the sibling was to stay with maternal great grandmother. The plan stated that the maternal great grandmother would ensure that contact with the child's mother and victim child's father would be supervised at all times. If either the mother or her paramour attempted to violate this agreement, the maternal great grandmother would contact police and the agency immediately.

Current Case Status:

The county children and youth agency did [REDACTED] both of the victim child's parents on the prior injuries to the victim child. However, those injuries were not related to the child fatality. Law enforcement arrested both parents on 9/26/11. The charges pending were for aggravated assault, involuntary manslaughter, simple assault, endangering the welfare of a child and reckless endangering another person. The case has not yet gone to trial. The father is currently in the Perry County Prison and the mother is in the Mifflin County Prison. Upon completion of this report the victim child's mother has decided to accept a plea agreement with the district attorney's office. She will plead guilty to involuntary manslaughter and all other charges will be dropped. In the agreement the victim child's mother will be able to recuse herself from having to provide specific testimony as to what occurred to the child. Upon completion of this report there was no mention of a plea agreement being agreed upon or accepted for the father of the victim child. Sentencing is scheduled for June 2012.

The county agency still maintains an ongoing case for the surviving sibling who has remained in the care of the maternal grandmother. The agency has maintained the ongoing case to assist the maternal grandmother with [REDACTED] [REDACTED]. The agency does intend to close the case in the near future as there are no reported concerns with the care of the child in the grandmother's home.

County Strengths and Deficiencies as Identified by the County's Fatality Report:

The county's report did not note any particular strengths or deficiencies identified from the fatality review meetings held by the county. There was mention during the meeting over the concern with the lack of medical response by medical providers who had involvement with the victim child prior to the fatality. The victim child's pediatrician evaluated the child in December 2010 at which time the child was considered to be [REDACTED]. A report was never made to the county children and youth agency or ChildLine. The child was not scheduled for a follow up appointment until the next month. The child was treated by another medical provider for a [REDACTED]. The child was not provided a full skeletal exam, this is concerning because it would later be discovered after the child's death that he had [REDACTED] which never was treated. Again no report was made to ChildLine or the county children and youth agency regarding concerns of abuse or neglect. Upon the child's death the hospital did not make a report of the death to ChildLine or the county children and youth agency. The county made mention of a need to provide education to medical providers on the topic of mandated reporting. The county reflected on prior history with the family. There was mention of multiple referrals on the family pertaining to issues with mother and reported drug usage while in the presence of her children. The county review team discussed the prior six [REDACTED] received. The county offered the family services however the family was not willing to participate in services offered. On the referrals the agency assessed there was never evidence of injuries to the children or visible evidence of neglect. The agency had no definitive evidence on how the behavior displayed by the parents was affecting the care of the children. Once again the mother passed drug test when administered and mentioned that if she did choose to partake in that type of activity then arrangements would be made to ensure another caretaker would be watching the children. Another topic of discussion during the meeting was increased community outreach in the county through PA Family Support Alliance and Porch Light Project which can offer additional support and training for families and community members in regards to abuse and neglect.

County Recommendations for changes at the Local Levels as identified by Fatality Report:

The county's report did not identify any specific recommendations for change. During the meeting there was mention of one specific area for concern at the local level is prescription drug abuse. The county agency has experienced increased referrals regarding this issue in recent years. The agency administrator referenced several prescription drug overdoses that have occurred in the county over the past year and agency [REDACTED] in which the mother is alleged to be abusing prescription medications. The team discussed the possibility of PCCYS attempting to reach out to pharmacies in the area to discuss efforts to mitigate prescription drug abuse.

Recommendations for changes at the State Level:

The county's report did not reference specific areas for change at the State level. There was discussion during the meeting regarding education of medical professionals on mandated reporting. Most of the medical services utilized by families in Perry County are located outside of the county itself. Medical services are mainly provided in neighboring counties such as Dauphin and Cumberland. For this particular fatality, Carlisle Hospital did not make a report to ChildLine. The victim child was seen by his primary care physician for well child exams prior to the child's death. The child was diagnosed as possible [REDACTED] during a physician visit in December 2010. The medical report from that visit made the recommendation for the child to come back for a follow up appointment in one month. The victim also received treatment for a [REDACTED]. However, none of the medical providers who came in contact with the child made a referral to Perry Children and Youth Services or ChildLine regarding concerns. A recommendation is for OCYF to discuss the concerns of needed mandated reporter training for medical staff.

Department Review of County Internal Report:

The Department received the county report on 5/21/12. Participation in the county agency's internal child fatality review meeting along with review of the information in the case record, the Department found the report to be limited. However, the meetings held had some discussion on topics such as mandated reporting by medical providers, lack of services in the county, issues with the report having to be called into ChildLine by the county children and youth agency, issue of prescription drug abuse within the county; discussion on number of referrals received on this family, as well as formal discussion on how the county would have to proceed with the investigation received prior to the fatality as the victim child had received injuries which were suspicious for abuse yet most likely those injuries would not necessarily be linked to the child's death.

Department of Public Welfare Findings:

County Strengths:

The county agency had good communication with law enforcement and appears to have a good working relationship with provider agencies. When the incident occurred, the county agency contacted ChildLine to ensure this incident was investigated as a [REDACTED] since the hospital had not called in the report to ChildLine. The surviving child was seen by the agency immediately; the caseworker had to contact a neighbor who had a four wheel drive vehicle to help transport the worker up the driveway since road conditions were bad at the time of the visit to the home to assure the sibling's safety. The sibling was given a medical exam which included a full skeletal exam to ensure she had no injuries. The child was also assessed using the ages and stages evaluation tool to determine her overall functioning. The county agency did implement a safety plan during their investigation which prevented unsupervised contact with the mother and father. The plan was revised the next day for the child to stay at the maternal great grandmother's home rather than remain at the address of

maternal grandfather. The agreement regarding no unsupervised contact with the mother and father remained. During prior [REDACTED] that the agency received regarding this family, the agency did attempt to engage the victim child's mother to open for ongoing services, however, the mother was reluctant to receive agency help or follow through with services offered within the community.

County Weaknesses:

The county offered services to the mother; however the victim child's mother was reluctant to participate. Due to the age of the children and factoring in age of parents along with the concern of the allegations utilizing a best practice approach the county should not have dismissed / screened out the two referrals on 2/5/10 and 10/28/10 rather the agency should have accepted for assessment. The county closed assessment 10/14/10 at that time the sibling of the victim child was to be seen again for a follow up appointment regarding issues [REDACTED]. The agency had to schedule with the provider to get the child seen for the first appointment in 9/10/10. The agency should have noted what came out of that appointment or assure the mother took her child to that appointment prior to closing. The agency then received another [REDACTED] on 10/28/10 which was screened out. Since there was multiple reports the Department would recommend a more thorough assessment of the family and children have been completed and the family opened for services if warranted. The county agency appeared to have enough circumstances to justify opening the family for services. In addition the review of the case record found no mention to family offering a family group decision making conference. This service may have provided value due to the fact the age of the mother was young and it appeared she was having family members assist in the care of her children. The referrals in which the agency assessed did follow [REDACTED] and the safety assessment process protocol to help assist in the agency's assessment.

Statutory and Regulatory Compliance issues:

Review of the county investigation and case file review found no areas of non compliance regarding this particular case.

Department of Public Welfare Recommendations:

The county agency had received multiple reports regarding the victim child's mother's alleged drug usage and how this affected the care of her children. The county agency was never able to confirm that the parents were incapacitated due to drug usage. The parents did admit recreational usage, however, both made it clear that if they did partake in that type of activity then the victim child's grandmother or another adult caretaker would watch the child; both parents denied using drugs in front of the children. When the victim child's parents moved into the home of the maternal grandfather (in July 2010) and resided in a separate area of the home actual monitoring of the parents by family members decreased. The Department recommends the county agency review their process of how they determine when it is necessary to open a family for ongoing services when multiple referrals have been received. The Department

should look into mandated training for medical providers to ensure medical staff are aware of the need to report suspected abuse or neglect to the proper authorities.