



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**REPORT ON THE FATALITY OF:**

Ryder Richter

**Date of Birth:** November 10, 2013

**Date of Death:** March 6, 2014

**Date of Oral:** March 6, 2014

**FAMILY WAS NOT KNOWN TO:**

Fayette County Children and Youth Services

**REPORT FINALIZED ON:**

May 14, 2015

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, DHS 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. Fayette 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>
Ryder Richter	Child	11/10/13
[REDACTED]	Mother	[REDACTED]/91
* [REDACTED]	Father	[REDACTED]/79
[REDACTED]	Maternal Grandmother	[REDACTED]/71
* [REDACTED]	Mother's Paramour	Unknown

\*Mother and child lived with maternal grandmother. The incident occurred in the mother's friend's home, but mother was not living there. The child's father was incarcerated and not a household member. The mother's paramour did not live in the home but was present on the day of the incident.

**Notification of Child (Near) Fatality:**

On March 6, 2014 Fayette County Children and Youth Services (CYS) received a referral identifying that a 3 month old male child was transported by ambulance to the local hospital. The child was unresponsive and arrived in cardiac arrest. Upon arrival to the [REDACTED], the child was pronounced dead. The initial report from the mother was that she and the child had been visiting with friends for the weekend. There were not enough beds, so the mother put an old couch cushion on the floor for the child to sleep on. On the day of the incident, the mother had put the child down to sleep around 12:30 pm. She allegedly checked on the child about 90 minutes later and he was still sleeping. The mother then took a nap. The mother reports waking up around 4 pm and noticed the child had been lying face down on the floor. When the mother picked the child up, she noticed he was "blue". She was unable to wake the child. Emergency services were called and arrived to the home within 9 minutes. Upon arrival, the medics were met outside by the mother with the child in her arms. The child was taken and placed into the

ambulance and was found to have no pulse. The emergency medic reported that it appeared that rigor had already set in with the child.

The examining physician spoke to the concern of the child's condition, reporting that the body temperature and the rigor stage suggested the child had been dead approximately 12-16 hours. The physician did not believe the statements given by the mother were consistent with the findings of the exam. The child had no external injuries; however, based on the child's condition and the inconsistent statement from the mother the child's death was [REDACTED] as the alleged perpetrator.

#### **Summary of DHS Child (Near) Fatality Review Activities:**

The Western Region Office of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. The regional office also participated in the County Internal Fatality Review Team meeting on April 23, 2014 where copies of the medical reports and autopsy were presented.

#### **Children and Youth Involvement prior to Incident:**

The agency had no prior history with the subject child. There is documented history of involvement with the mother as a youth. [REDACTED] became active with Fayette County CYC in 2003 due to truancy. At the time she was 11 years old and admitted to using drugs such as marijuana and cocaine. The case history was significant for a familial history of substance abuse and trauma. Both of her parents were abusing illegal substances and [REDACTED] had found her father dead from an overdose when she was 8 years old. [REDACTED] ultimately returned home in 2006. The agency identified continued substance abuse by her mother at that time and she [REDACTED] with a family friend. The friend was given legal custody and the case was closed in 2006. Six months later she was [REDACTED] at the threat of her mother absconding with her. She remained in care until she aged out at 18 in May 2009.

#### **Circumstances of Child (Near) Fatality and Related Case Activity:**

On the date of the incident, the CYC agency responded to the hospital and spoke with the examining physician. He reported that the child had been dead for a long period of time and the mother's timeframe was not consistent with his findings. Further medical tests found no notable injuries and the child did not appear underweight or malnourished.

Reports from hospital personnel document that the mother admitted to oral and injected use of [REDACTED], with the most recent injection occurring the day prior to the incident. The mother reportedly had [REDACTED]. The mother also admitted to taking [REDACTED] and cocaine. The worker noticed what appeared to be "bleeder" track marks on the mother's arms from recent injections.

Additional interviews were conducted with the volunteer EMT who arrived minutes before the ambulance as well as the treating medics.

The mother was later [REDACTED], with CYS participating. She reported that she and the child lived with her mother. She and her mother had an argument a few days prior and she took the child to stay with her boyfriend. She reported that her boyfriend lives with a friend and the friend's wife. The mother reported that they had been staying in the home with the boyfriend for a couple of days. The child appeared to be fine during the days leading up to the incident. She stated that she and the child were staying in one of the bedrooms with her boyfriend. The mother and the boyfriend slept on the bed while the child was placed on the floor on top of a comforter and baby blanket.

On the day prior to the incident, the mother reported changing the child and giving him a bottle and cereal around 6:30 am. After playing some, the child was put down for a nap about 9 am. She then took [REDACTED] and lay on the bed watching TV. The child woke around 12:30 pm and the mother gave him some baby food, a bottle and some yogurt. She stated they were awake for about four hours playing. She laid him back down around 5 pm. He slept until 9 pm, when he woke up and ate, and then went back to sleep around 12 am.

On the date of incident, the child woke around 8 am and the mother fed and changed him. She took [REDACTED]. She fed him again around 11 am and laid him back down to nap. He did not sleep for more than an hour and woke up "cranky and fussy". The mother stated that she laid him back down about 1:30 pm and he fell right to sleep. The mother also took a nap at this time. The child had been placed on his side and was sleeping on an old couch cushion on the floor. The mother woke up and found the child lying face down. She touched his back and realized he was not breathing and then noticed his color was bluish-purple. She yelled for her boyfriend who came upstairs with his friend. The friend performed CPR on the child while the boyfriend called emergency services.

Following her interview, the mother consented to a drug screen. She tested positive for [REDACTED], cocaine and [REDACTED]. Test results came back with high levels of cocaine. Mother did admit to using cocaine in the days prior to the death.

A visit was completed at the home where the child and the mother had stayed. All of the adult household members were interviewed as well as the two young children who reside in the home. Statements alluded to concerns that those in the home rarely saw the child.

Additional attempts [REDACTED] the mother were made by the county caseworker; however she either canceled or did not show. An attempt was also made [REDACTED] the father of the child, who had been incarcerated at the time; however, he had absconded after being granted a funeral pass for the child's funeral. A later attempt was successful with the father after he was located and returned to prison. He was advised to the case status and reported he believed the mother to be a "good mother".



it on the local Act 33 report. The recommendation does not accurately correlate to this report, however may be justified in future situations.]

- Recommendations for Change at the State Level: No recommendations for change on the state level were noted.

**Department Review of County Internal Report:**

The Department received the final Act 33 Review Report dated July 28, 2014. The Department provided written agreement on this date to the strengths and recommendations put forth by the team.

**Department of Human Services Findings:**

- County Strengths: The County's response to the report was an overall strength. There was immediate contact with the hospital personnel and law enforcement officers regarding the status of the case. Interviews with the parents and other imperative persons were completed timely.
- County Weaknesses: There were no weaknesses noted on this investigation.
- Statutory and Regulatory Areas of Non-Compliance:  
No statutory and regulatory areas of non-compliance were noted.

**Department of Human Services Recommendations:**

In addition to the recommendation set forth by the review team, the Department makes the following recommendation:

- Per Act 33, a local review meeting must be conducted within 30 days of the start of the child death investigation unless the case was unfounded and ChildLine received the CY-48 within 30 days of the date of the ChildLine referral. The date of the ChildLine report to the county was March 6, 2014 and the local review was not conducted until April 23, 2014. It is recommended that Fayette County review current policies and procedures in place regarding the commencement of local review meetings.
- In regard to the final Act 33 Review Report, the Department acknowledges that some of the requirements were included, however it would be recommended that the county revise the current Act 33 report to include the required information pertaining to the following:
  - Deficiencies and strengths 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 child abuse and neglect;
  - 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 and neglect.