



**REPORT ON THE FATALITY OF:**

**JASPER HOLMES**

**DATE OF BIRTH: 09/01/2011**  
**DATE OF DEATH: 02/20/2012**  
**DATE OF ORAL REPORT: 02/10/2012**

**FAMILY KNOWN TO:**  
**Erie County Office of Children, Youth and Families**

**REPORT FINALIZED ON: 04/26/2013**

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. Erie County has convened a review team in accordance with Act 33 of 2008 related to this report. Their findings will be summarized in this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Jasper Holmes	Child Victim	09/01/2011
[REDACTED]	Biological Mother	[REDACTED] 1990
* [REDACTED]	Biological Father	[REDACTED] 1987
[REDACTED]	Mother's Paramour	[REDACTED] 1990

**Other involved person:**

\* [REDACTED] Paternal Grandmother

\* Indicates non-household member

**Notification of Child Near Fatality/Fatality:**

On February 9, 2012, the victim child, Jasper Holmes, was taken to Hamot Hospital and was found to be [REDACTED]. The treating physicians were able to revive Jasper; however, he was [REDACTED]. Hamot Hospital completed a CT scan and found the child sustained a [REDACTED]. In addition, Jasper was found to have scratches and "red marks" near his right eye. The treating physician at Hamot Hospital certified Jasper to be in critical condition due to [REDACTED]. Due to the severity of his injuries, Jasper was transferred via medical helicopter to Children's Hospital of Pittsburgh, where he was placed [REDACTED].

At 10:30 AM, Erie County Office of Children and Youth (OCY) received a referral from the [REDACTED] advising them of the child's injuries. According to the initial reports from the mother, the injuries may have occurred between February 7 and February 9, 2012.

The Department received notification of this report on February 10, 2012, which prompted a preliminary near-fatality report to be completed. Although a near fatality report was done on February 10, 2012, the child was found to have no [REDACTED] after eleven days and was subsequently [REDACTED] pronounced dead on February 20, 2012.

#### **Summary of DPW Child Fatality Review Activities:**

Upon receipt of the near-fatality report on February 10, 2012, the Department contacted Erie Co. OCY to review the allegations and gather the necessary information for the preliminary report. In addition, a copy of the complete record was requested of the county and subsequently provided and reviewed.

This writer participated in OCY's child fatality multi-disciplinary team (MDT) meeting on April 16, 2012. The child's medical records and medical report from the [REDACTED] were distributed as reference materials for the team. Also on April 16, 2012 the paternal grandmother and father were interviewed at their residence, as the paternal grandmother contacted the Department with concerns regarding how Erie Co. OCY handled the case while the child was [REDACTED]. This information will be incorporated into the Department's findings at the end of the report.

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

Prior to the incident, Erie County OCY had no prior history with the child. It was noted in the file, however, that Erie County OCY had provided services to the mother as a child due to her mother (the maternal grandmother of the deceased child) having substance abuse issues.

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

According to Erie County OCY, they received the report regarding the child from the [REDACTED] on February 9, 2012 at 10:30 AM. The [REDACTED] [REDACTED] to the Emergency Department (ED), as the child arrived via ambulance after being found in [REDACTED] and also being diagnosed with [REDACTED].

At 11:00 AM, the assigned OCY caseworker and an OCY intern responded to Hamot Hospital, where she met the [REDACTED]. The caseworker and [REDACTED] then spoke with the child's mother, who was present at the hospital with the child. During this interview, the mother reported that she was not home at the time of the incident and that her paramour was caring for the child. (The caseworker's notes do not reflect where the mother was when she left the child alone with the paramour.) The mother reported that the paramour claimed he was walking while holding the child, tripped, and the child hit his head on a car seat. At approximately 3:00 or 3:15 AM, the mother said the child stopped breathing. As a result, she claimed that she "pushed on his

chest and he started breathing again" so she watched him through the rest of the night.

In the morning at approximately 8:00 AM, the mother stated she and the paramour went outside for a cigarette and left the child sitting in a car seat for no more than five minutes. Upon returning to the room, they found the child "slumped over" in the car seat. He had spit up formula and was not breathing. At this point, they contacted 911.

While speaking with the caseworker, the mother identified the father of the child; however, stated he was "not very involved" and had not seen his child in two months. The mother has a new paramour, whom she had been dating for five to six months at the time of the incident. The child's father arrived at the hospital while the worker was present. The intern obtained demographic and contact information from him. He and the mother were observed speaking to each other while their child was being treated for his injuries.

Due to the extent of the child's injuries, he was flown via medical helicopter to Children's Hospital of Pittsburgh (CHP).

At 1:52 PM on February 9, 2012, OCY received a [REDACTED] report from [REDACTED] regarding this child's injuries. It was also registered as a near fatality report on February 10, 2012, as the child was treated [REDACTED] at Hamot Hospital, who certified the child to be in critical condition as a result of [REDACTED].

After the child arrived at CHP in the afternoon, [REDACTED] contacted OCY at 3:00 PM and advised the worker that she was preliminarily diagnosing the child as a victim of [REDACTED] and stated that the child was [REDACTED]. During this conversation with [REDACTED] the worker informed her that "one of the stories that are being told" was that the child was given Tylenol tablets dissolved in his formula. [REDACTED] agreed to test for this.

The caseworker has a case note entry dated February 9, 2012 at 4:00 PM that states the mother told [REDACTED] that she slapped the child across the face and that they were looking at her [REDACTED].

In a Supervisory Review entry dated February 9, 2012 the supervisor notes "bio dad found," minimally described the explanation of the child's injuries, and that the child's outlook was "not good."

On February 10, 2012, [REDACTED] contacted the worker to advise her of the child's injuries. According to the case note entry, the child [REDACTED] was willing to state that the injuries did not occur earlier in the week (Monday or Tuesday; February 9, 2012 was a Thursday). The mother initially reported that she noticed bruising to the left side of the child's face. When confronted with the fact that the bruising observed by

the doctors was on the right side of his face, the mother said the bruises got worse between 2:00 and 5:00 AM. This led the doctors to date the injuries to the morning of the February 9<sup>th</sup>.

In additional questioning by [REDACTED], the mother reported to her that a week or so ago, the child had a "really bad bruise" to his left ear. This allegedly happened when mother, child, and mother's paramour were staying with friends of theirs. The mother stated the female friend told her that mother's paramour had "nibbled on the ear," mom said he "chewed" on the ear. However, the ear they indicated this happened to was the left one and the current injuries are on the child's right ear. The mother reportedly was sent a cell phone photo by the child's uncle, although a name of this uncle was not provided. [REDACTED] requested a conference call with [REDACTED] to discuss her concerns.

In the afternoon of February 10, 2012, the agency obtained an emergency protective custody order of the child. The parents were notified verbally while they were at the hospital and copies of the order were faxed to the [REDACTED] [REDACTED] who agreed to serve the parents.

A Supervisory Review occurred on February 10, 2012. It describes [REDACTED]  
[REDACTED]

The OCY worker met the [REDACTED] for a conference call with [REDACTED] reiterated her concerns and advised that the mother and paramour's accounts of the incident were "about the same." The paramour worked from 10:30 PM to 7:30 AM. When he came home, the child was "fussy." They went outside to have a cigarette and left the child in a car seat. When they came back in, they found the child wasn't breathing. According to the parents, the paramour took the child into the shower to try and wake him. They tried tickling the child's feet, and also tried placing a wet cold washcloth on the child. [REDACTED] indicated that in her experience, these are things done by parents when they have hurt their children. [REDACTED] believes that the mother knows what happened to the child and is not willing to tell. She also found it odd that the mother was not blaming her paramour for the injuries.

On February 11, 2012, the father of the child contacted the agency to ask if he needed to be in attendance at the court hearing scheduled for Monday, February 13, 2012. Father was advised it was in his best interest to be present.

The detention hearing was held on February 13, 2012 and the agency maintained custody of the child. While the worker was speaking to the maternal grandmother (unspecified which one), the grandmother commented that she had noticed a "red blood spot" on the child's head approximately three weeks prior to this. The grandmother believes that mother caused the injury or knew what happened.

Later on February 13, 2012 the paternal grandmother called the agency to state her son, the child's father, received a phone call informing him that the child was

██████████ and they were going back to the hospital. The grandmother informed the caseworker that should the child be able to be discharged at some point, she was willing to take the child and his father into her home.

A telephone call to the caseworker from ██████████ also occurred on February 13, 2012. ██████████ called to inform the agency that the child ██████████ and may not survive. ██████████ She also confirmed the grandmother's statement that the father received a phone call informing him that the child was ██████████ and would be in a ██████████ ██████████ At this point in the child's treatment, the physicians were going to talk to the family about ██████████.

A conference call between the caseworker, ██████████ ██████████ took place on February 13, 2012 as well. During this call, ██████████ informed the caseworker that mother has added a new element to her initial version of what happened when they found the child unresponsive in the car seat. She was now stating that after he didn't respond from being in the shower her paramour took the child over to the bed and dropped him on his back from about twelve inches high "to wake him."

On February 14, 2012 a meeting took place between the agency, the parents, and the hospital staff. At this meeting, the parents requested using the paternal grandmother as the caregiver of the child should he return home. His prognosis remained poor at that time.

On February 16, 2012 the paternal grandmother contacted the agency to express frustration about the delay with ██████████ ██████████

██████████ The grandmother also expressed concern over the mother being allowed to make medical decisions regarding the child. The caseworker explained to her that as long as the mother maintained parental rights to the child, she was able to make decisions.

On February 17, 2012 ██████████ called the agency to advise them that she believed the child would not survive the weekend. She also informed the agency that after a skeletal survey, the child was found to have suffered past incidents of ██████████ The child had ██████████ in the past (unspecified locations) and the child also suffered ██████████ recently, which included ██████████ ██████████ (In a later phone call on February 20, 2012 the ██████████ informed the caseworker that the two prior injuries were ██████████ ██████████ They were dated to be approximately 14 days old.)

The ██████████ contacted the agency on February 19, 2012 to inform them that the mother was requesting to remove the child from ██████████ and the hospital wanted to know if OCY was going to "intervene with the mother's wishes." OCY's solicitors were consulted and it was determined that "since the child was not adjudicated that OCY will not intervene with the mother's medical

wishes." (It should be noted that at this time, the agency had already taken Emergency Protective Custody of the child on February 10, 2012 and detained the child as per an Order of Court dated February 13, 2012.)

On February 20, 2012 a conference call was held that included the agency, the District Attorney's office, the police, and hospital staff. The hospital reported that [REDACTED], so the child wasn't [REDACTED] but his condition "will not improve dramatically." A discussion was also held with the family regarding the [REDACTED] found. The [REDACTED] described the mother as looking "like a deer caught in the headlights." The family was also counseled on their decision to [REDACTED] for the child. [REDACTED] was giving the family the weekend to decide. According to the caseworker's case note, the [REDACTED] reported that the family requested to speak with the [REDACTED]. As part of that discussion, it was "mentioned" that OCY has the child "under order" which resulted in the call made on the 19<sup>th</sup> as described previously.

At 11:30 AM on February 20, 2012 [REDACTED] contacted the agency to make sure they were aware that "the family" was in discussion about [REDACTED] for the child. At 4:00 PM the [REDACTED] contacted the investigators to inform them that the mother decided to [REDACTED] for the child. The child passed away at 4:47 PM.

There is another supervisory review entry dated February 21, 2012 that states "family discussing [REDACTED]." Another supervisory review occurred on February 22, 2012 that documents that "child [REDACTED]. TBC." (To be closed.)

On February 22, 2012 the paternal grandmother contacted the agency very upset about the mother [REDACTED] from the child because she claimed her son was never contacted or consulted. Agency staff informed the grandmother that the agency did not "have the ability to prohibit the mother from making that choice." The grandmother was directed to contact the hospital to learn their protocol in those situations. In addition to these concerns, the grandmother asked when her son was to have [REDACTED]. She was advised that the agency was no longer requesting [REDACTED] but she could contact the coroner's office to inquire [REDACTED]. She was also advised that due to the child's death, there was no need for a hearing that was scheduled for February 23, 2012.

On February 29, 2012 the agency determined that the child was [REDACTED] by submitting their [REDACTED] with an [REDACTED] status and naming both the mother and her paramour [REDACTED]. Both the mother and paramour were arrested and charged with criminal homicide, aggravated assault, endangering the welfare of a child, and recklessly endangering a child. One final supervisory review entry dated February 29, 2012 reflects the mother and boyfriend were arrested. The investigation was closed on March 1, 2012.

**Current Case Status:**

On April 11, 2013, the mother pled guilty to felony Endangering the Welfare of Children, for which she was sentenced to a minimum of 12 months and no more than a maximum of 48 months confinement.

On April 15, 2013, the mother's paramour pled guilty to misdemeanor Endangering the Welfare of Children. He is awaiting sentencing at the time of this writing.

**County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:**

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. Erie County convened a review team in accordance with Act 33 of 2008 related to this report and held a meeting on April 16, 2012. As per the county's report, the following are their findings:

- **Strengths:**
  - Communication from the start between OCY, the District Attorney's office, the local police, and the medical personnel
  - Local police involvement; they were receptive to help from OCY
  - The hospital staff was timely and responsive
- **Areas of Concern:**
  - The child's PCP did not contact OCY when the child had not been seen since the age of two months. If they would have known about [REDACTED] pre-natal history and domestic violence, it might have helped.
  - There were concerns about family members taking pictures of injuries they saw on the child, but not contacting OCY
  - There were concerns with the caseworker conducting the investigation not interviewing the friends of the family with whom mother, child and paramour resided, as well as not verifying information submitted by the PCP.
- **Recommendations for Change at the Local Level:**
  - Increase community awareness about what to do when they suspect [REDACTED] Family and friends saw injuries on the child within the weeks preceding the incident that led to his death but no reports were made to OCY.

- Continue to work on child abuse task forces.
- Work on outreach to motels/hotels in the area, possibly providing them with pamphlets. At the time of the incident, the family was living in a motel.
- Continue to reach out to primary care physicians
- Look into holding additional Front Porch Project trainings for the general community (Boy Scouts, bus drivers, churches, neighborhood watch groups, PTA members).
- Recommendations for Change at the State Level:
  - The team did not identify any recommendations for change at the state level.

#### **Department Review of County Internal Report:**

The Department received Erie County OCY's internal report of the child's death in May of 2012. Attached to the report is a summary of OCY's involvement with the family from the time of the referral through case closure. There was no prior history with the child to report.

As for strengths, the Department agrees that the agency, local law enforcement, and the District Attorney's office did a good job conducting a joint investigation. They maintained regular contact with the medical professionals treating and assessing the child and convened either in person or via speakerphone to discuss the investigation. And, as stated in the report, the medical professionals at Children's Hospital of Pittsburgh were an important part of the investigation, as they routinely updated the investigators with their findings and the child's condition.

The Department also concurs with the Areas of Concern as identified by the county's internal review; however, the review did not include some issues specific to the county's casework activities that are outlined in the Department's findings within the next section.

#### **Department of Public Welfare Findings:**

- County Strengths:

As stated above, the county did a good job conducting a joint investigation with law enforcement, including the District Attorney's office. Interviews were conducted jointly, conference calls with the physicians and social workers took place, and information was shared between all parties when learned.

The agency utilized the court to ensure further protection for the child should the child have survived. In addition, the agency was willing to consider the paternal grandmother's home for a placement if he would have become well enough to leave the hospital.

During the short investigation, the agency did speak with other parties about any prior suspicions they had about the child, such as the maternal and paternal grandmothers.

The county's near fatality/fatality review team is very organized and efficient. The agency does very well in convening these meetings and ensuring they have more than adequate representation.

- County Weaknesses:

When reviewing the case notes in the file, there are areas where gaps exist and it appears as though contacts with persons involved in the case may not have been documented or documented well enough.

- For instance, a dictation entry dated February 9, 2012 at 3:00 PM describes a phone call between [REDACTED] and the caseworker. In this entry, the caseworker tells [REDACTED] that "one of the stories being told is that the child was given Tylenol tablets dissolved in his formula." There is no prior dictation entry about this, nor does the worker clarify in this entry from where that statement came.
- There were two people with whom the mother, child, and mother's paramour resided that allegedly had concerns about the mother and paramour's parenting and treatment of the child. Although the worker was given this information on the second day, of the investigation, they weren't interviewed. The rationale was that these two persons could be potential witnesses in the criminal investigation. Again, there is nothing in the case notes where the police request that they not interview these persons. The 3490 regulations require a worker to interview anyone that may have or is likely to have information related to the investigation.
- A case note entry dated February 16, 2012 at 11:00 AM revealed more than one concern. The paternal grandmother called in with [REDACTED] and she was unhappy with the delay. While there is mention in the dictation that [REDACTED], nowhere in any previous dictation is there a statement about a [REDACTED] test or who was requesting it. In addition, it is unclear why this test, which appears to have been requested by OCY, was being completed. From the very first case note entry, the worker identifies the father as "bio-dad". In addition, none of the family members from either side of the family refute that he was the father. This includes the

child's mother. The lack of recognizing him as the father caused further problems for the family and resentment towards the agency.

- The agency obtained Emergency Protective Custody of the child on February 10, 2012. When it became apparent that the child's condition was not going to improve, discussions with the family began concerning [REDACTED]. This is documented in a case note dated February 19, 2012 at 9:30 PM. The hospital contacted the agency to ask how they should handle the situation, as mother was inquiring about [REDACTED]. The caseworker consulted with the agency solicitor about how to answer the hospital staff. The response that is contained in the caseworker's case note is "the child was not adjudicated and that OCY will not intervene with the mother's medical wishes." It should be noted that that the agency had legal custody of the child at the time of this call and a full dependency hearing was scheduled for February 23, 2012. It is however recognized that even with the emergency custody, the mother maintained rights to make medical decisions for the child.

On February 20, 2012 the caseworker has a phone call with [REDACTED]. The worker documents that "the family" was in discussion about [REDACTED]. There is no clarification as to who "the family" includes. Subsequently, the mother decides to [REDACTED] on February 20, 2012 and the child passes away at 4:47 PM.

On February 22, 2012, the paternal grandmother called the agency understandably upset that her son was never contacted regarding [REDACTED] for the child. The delay [REDACTED] also caused a struggle for the father and his family in regards to the child's remains. The disconnect regarding the matter of [REDACTED] in an expedited manner and involvement of the father in decisions regarding the child's medical condition, whether legally required to or not, are being identified as practice issues that impeded family engagement.

- Statutory and Regulatory Areas of Non-Compliance:

While there were gaps in case notes, it is unclear the reasons. However, the agency was in violation of 3490.55 (d) related to interviewing persons that may have information related to the investigation. A Licensing Inspection Summary will be issued requiring the agency provide a corrective action plan.

**Department of Public Welfare Recommendations:**

1. Periodic reviews of case notes should occur by the supervisors and agency quality assurance staff to ensure that the case notes accurately reflect the case activities. It is best practice to have documentation written so that someone that is unfamiliar with the case can read through the notes and understand what is going on. The gaps discovered left

questions as to where information came from and why decisions were made by the agency.

2. When the agency has custody of a child and the child is [REDACTED] such as this, it should make every attempt to ensure that both parents are fully aware of what is happening in regards to that child's treatment (provided they maintain parental rights).
3. The agency appears to have requested DNA testing from the person that they listed throughout their case notes as the "bio-dad" or father of the child. If testing was really necessary and they request it, then the agency should expedite the testing to avoid further complications in situations such as described in this report.