



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

RYELEY BEATTY

Date of Birth: May 02, 2011
DATE OF DEATH: July 06, 2014
DATE OF ORAL REPORT: July 04, 2014

FAMILY WAS KNOWN TO:

Beaver County Children and Youth Services

REPORT FINALIZED ON: 5/7/15

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. Beaver 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> |
|---------------|----------------------|-----------------------|
| Ryeley Beatty | Victim Child | 05/02/2011 (3) |
| [REDACTED] | Mother | [REDACTED] 1986 (28) |
| [REDACTED] | Father | [REDACTED] 1986 (29) |
| [REDACTED] | Sibling (deceased) | [REDACTED] 2012 (2) |
| [REDACTED] | Sibling | [REDACTED] 2009 (5) |
| [REDACTED] | Sibling | [REDACTED] 2006 (9) |
| [REDACTED] | Sibling | [REDACTED] 2010 (4) |
| [REDACTED] | Maternal Grandmother | Unknown |
| [REDACTED] | Paternal Grandfather | Unknown |
| [REDACTED] | Paternal Great Aunt | Unknown |

*Prior to the incident [REDACTED] resided with her maternal grandmother for most of her life, although she did have regular contact with her family. [REDACTED] lived across the street from the family home with paternal great grandfather and paternal great aunt, because the children were used to being in the home with them and the entire family lived in the home prior to moving into their own home.

Notification of Child (Near) Fatality:

On July 4, 2014 a referral was received by Beaver County Children and Youth Services alleging that child and her 2 year old sibling were climbing on a dresser and it fell on the children. The child was [REDACTED] in critical condition. The doctor was not suspecting child abuse of any kind at that time, however was concerned for a lack of supervision. It was unknown at that time where the parents were when the incident occurred. The child passed away on July 6, 2014. Upon receipt of the report, the county had concerns that suggested a possible failure to act by the parent and the report

was subsequently registered as a fatality [REDACTED] on July 9, 2014.

Summary of DHS Child (Near) Fatality Review Activities:

The Western Region Office of Children, Youth and Family Services obtained and reviewed all current case records pertaining to the family. The regional office also participated in the County Internal Fatality Team meetings on July 30, 2014.

Children and Youth Involvement prior to Incident:

On May 07, 2012, the agency received a referral that the mother tested positive for amphetamines after giving birth to her 5th child [REDACTED]. She had no reason for the positive test result except that she took cough syrup about 1.5 months ago. Mother had reportedly received no prenatal care during the pregnancy. She stated that she was refused medical care because she did not have medical insurance. Child's drug screen was negative. [REDACTED]

The caseworker completed a home visit and observed the home and other children in the home to be safe. The caseworker met with both grandparents and felt that they were a strong support for mother. Mother and Father denied any drug abuse issues and the caseworker observed no signs of drug use in the home. Following the assessment, it was recommended that mother have a parenting evaluation. A parenting evaluation was not recommended for father but he was supportive in ensuring that mother arrived to the evaluation. The recommendation from the evaluation encouraged the parents to attend a class or group on parenting, to be taken together, to specially assist the parents in developing a better co-parenting system. Additionally, the county recommended that an evaluation be scheduled for the family's 4 year old son, to determine his level of need. Case management services were offered to the family to support the mother with finding additional resources. The family was encouraged to continue scheduled respites with the natural support system to provide the mother personal time. The case was not accepted for ongoing services and after determining the children to be safe, the case was closed June 28, 2012.

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

On July 4, 2014 the caseworker received a call from [REDACTED] stating that the child's sibling had died at Aliquippa Hospital. The cause of death was noted to be asphyxiation due to chest compression. The subject child had been life flighted to Children's Hospital of Pittsburgh and was not expected to survive. Per [REDACTED], the child and her sibling were home with their father when the dresser in the bedroom fell down on top of them. The approximate weight of the dresser was 128lbs. [REDACTED] stated that preliminary feeling was that the incident was an accident. Father reported that the child and her sibling were sitting in the bottom drawer of the dresser when it tipped

over. Father reported that he was in the bathroom getting a bath ready for the children when the incident occurred. Father reported that he heard a "thump" and he called out to the children. He got no response but he did not go to see if the children were okay. [REDACTED] [REDACTED] also reported that when they entered the home there was no wetness in the bathtub and no signs that bath water had been in the tub. Mother was reportedly out of the home when the incident occurred, but knew the children were playing in the bottom of the dresser before she left the home.

On the date of the report the caseworker completed a home visit. [REDACTED] [REDACTED] were [REDACTED] including the dresser and any contents including the top of the twin mattress. The bottom drawer reportedly had a great deal of blood in it apparently from one of the children and the top mattress of the twin bed also had blood on it. [REDACTED] also reported that subject child was bleeding out of her vaginal area, but he did not feel that the blood coming out of the subject child's vaginal area was the main source of blood because there was so much blood inside and outside of the drawer. [REDACTED] believed the blood to be the result of one of the children having a ruptured spleen. During the home visit, the caseworker had observed the home to be in deplorable conditions. The worker observed what appeared to be feces on the crib rail and the wall next to the crib. The floor in the children's bedroom was covered in clothing and various other items. [REDACTED], feces were also found on the floor. Throughout the home the floors were covered with clothing, bags and other items making it difficult to walk through the home. The kitchen had dirty dishes stacked in the sink and garbage and other trash stacked on the kitchen table. The living room had bags and clothing and other items cluttered on the floor again making it difficult to walk. The code enforcement officer was contacted and he stated that the conditions were bad and the house was deemed to be uninhabitable. The home was tagged by the code officer and as a result the family was not able to live in the home. The family was required to find clean housing. Upon report back to the agency, the caseworker was advised by the county case manager [REDACTED] the 3 remaining children who, at that time, were with family members.

Also on the day of the report, the caseworker went to Children's Hospital of Pittsburgh to speak with the mother and father who were at the hospital with the child. According to the medical staff the child was not doing well and would be having her [REDACTED] [REDACTED] completed with the next day. The medical staff reported that if there was no brain activity at that time the child will be declared deceased. Two days after the incident, the child had a poor night in the hospital and the decision was made to remove life support. The child passed away on Sunday, July 6, 2014.

Joint interviews were completed with the mother, involving the caseworker, [REDACTED] [REDACTED]. The mother reported that she woke that morning at approximately 10:00am and father got up at approximately 11:00am. She reported that the father sent her to the store and that the father was mowing the lawn when she left the home. Mother stated that while she was in the store she received a call from father's aunt reporting that there had been an accident at the home and she needed to come home immediately. Mother reported that the father told her he was going to give the children a

bath and was in the bathroom when the dresser fell on the children. Mother reported that when she got up she heard the girls playing in their room, but she did not feed them or get them up because father was supposed to do that. Mother stated when she left the home the children were playing with the bottom drawer of the dresser. This was reportedly something that they did often and used the drawer to change the channel on the television. Mother denied any concerns regarding father's ability to care for the children. Mother denied a history of drug and alcohol abuse by her or father.

The father was interviewed separate from the mother. [REDACTED] that interviewed the father reported that the father changed his story and reported that he knew the children were in the bottom drawer of the dresser and that he was actually going to the bathroom when the incident occurred, not preparing a bath. Father reported that he heard the dresser fall but he remained in the bathroom for another 12-15 minutes before going and checking on the girls. Father reported when he came out of the bathroom and saw the dresser on the children he ran down the stairs and out of the house and across the street to his aunt's house to get her phone to call 911. The paternal great-aunt was actually the one who responded to the children and started giving CPR. [REDACTED] that the father stated that he did not do anything for the children when he saw them because he went to get the phone to call 911. Based on the father failing to respond to the children for an extended period of time after he heard the dresser fall, a coroner's inquest about the matter was explored and criminal charges against the father were subsequently filed.

Caseworker spoke with paternal great grandfather and paternal great aunt to inquire about them keeping the boys in their home, which they agreed to do. Additionally, the maternal grandmother was contacted to confirm that she was willing to maintain care of the oldest daughter, which she agreed to do.

[REDACTED]

Current Case Status:

On July 24 charges were filed against both parents. The charges included two counts of reckless endangerment on both the mother and the father and two counts of involuntary manslaughter on the father. The parents were arrested and released from jail on a \$25,000 unsecured bond. The preliminary hearing for the charges was scheduled for July 31, 2014.

Although the initial autopsy report revealed that if father would have responded the children would have survived, the father's charges of involuntary manslaughter were dropped to endangering the welfare of a child after the coroner's final report indicated that father would have only had a 30 second window to react to the children. Based on this information the Judge and the district attorney agreed that the father's charges should

be reduced. Both charges of reckless endangerment remained with both the mother and father's charges still pending.

[REDACTED] Both parents were required to have supervised contact and father was not permitted to stay the night in the home but could be at the home all day.

On August 13, 2014 the child abuse allegations against mother [REDACTED]. Both child abuse reports against father were [REDACTED] resulting in a physical condition and death.

[REDACTED] The home was found to be cleaned and the deplorable concerns had been corrected. The family returned to the home of the incident and per the caseworker the siblings have settled into the home nicely.

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

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- **Strengths:** The Act 33 review identified several strengths with the case management and investigation of the report. The children and family members were all interviewed in a timely manner. There is a strong extended family support. The parents have remained cooperative and open to services and recommendations made by the caseworker
- **Deficiencies:** The Act 33 team review found no deficiencies with the investigation process at the time of the review.
- **Recommendations for Change at the Local Level:** There were no recommendations at the local level.
- **Recommendations for Change at the State Level:** The Act 33 review identified that this was a tragic accident that may not have occurred with proper supervision and child safety measures. The system of care would not have knowledge of this internal safety issue without a referral to the family. There were no recommendations made.

Department Review of County Internal Report:

The Department received the county Internal report at the Act 33 meeting on July 30, 2014. The Department agrees with the strengths and recommendations set forth by the report.

Department of Human Services Findings:

- County Strengths: The county agency responded immediately upon receiving the report. The county acted quickly to ensure the safety of the siblings and went to the hospital to be a part of the interview process of both parents. The caseworker completed visits with family members who were previously and currently caring for the remaining children. The agency gathered very detailed information which contributed to the thorough assessment surrounding the circumstances.
- County Weaknesses: Regarding the previous referral, a concern surfaced involving the recommendation for the parents to receive or attend parenting sessions. It is unknown if the parents followed the recommendation prior to intake being closed. The Department considers the idea that improved monitoring of the recommended services could have prevented the poor safety decisions by the parents and the incident could possibly have been prevented.
- Statutory and Regulatory Areas of Non-Compliance:
There were no statutory or regulatory areas of non-compliance.

Department of Human Services Recommendations:

In addition to the above mentioned recommendations made within the Internal County Report, the following recommendations are brought forth by The Department.

- It would be recommended that the agency develop a practice when completing home visits, the workers are checking for proper use of furniture and identifying with the family potential safety threats with improper use. Additionally, the worker would be providing recommendations and resources on how to correct those potential threats.
- It would be recommended that clarification be sought as to whether there is a federal law regarding anchoring systems to secure furniture properly to a wall. Take steps to seek out information that landlords and home owners can be made aware of regarding proper installation of furniture. Consideration of a public service announcement that can be developed to get the information out to those who would benefit may potentially prevent this type of tragic incident.