



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Erica Barnes

BORN: 01/12/2010

DIED: 01/22/2010

FAMILY NOT KNOWN TO:

Dauphin County Children & Youth Services

DRAFT DATED: 05/03/2011

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and child near-fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Erica Barnes [REDACTED]	Victim child	01/12/2010 [REDACTED]
	Mother	
	Father	
	Half-brother	
	Sister	

Notification of Fatality

On January 22, 2011, Dauphin CYS received a referral [REDACTED] regarding mother and her children. On January 22, 2011 the victim child, 10 days old, was deceased, and at Harrisburg Hospital. Child's mother reported that earlier in the day she fed the child about 3 oz. of formula in a bottle, swaddled her, and put her back to bed at 5:30 a.m. in her bassinet. Mother got up around 11:20 a.m. to get ready for a doctor's appointment and noticed the child wasn't breathing. Mother called 911 and attempted CPR. Emergency responders and Emergency Room personnel were unable to revive the infant.

An assistant district attorney and local police officer were at the hospital with the CYS caseworker on January 22, 2011 and CYS maintained contact with the coroner's office and police thereafter. An autopsy was performed on 01/26/10, but results were pending. Harrisburg Area Police indicated that they had conducted initial interview of the parents on 01/22/10 but were waiting for the autopsy report to do follow-up. CYS participated on the County Child Death Review Team (a routine committee that reviews all child deaths in the county regardless of cause) on April 23, 2010. At that time, the coroner and pathologist voiced some disagreement regarding the child's cause of death. It was agreed they would notify CYS [REDACTED] was suspected. The case was closed at low risk on 03/04/10.

On October 14, 2010, [REDACTED] about this infant's death, noting that [REDACTED] had ruled her death a homicide. [REDACTED] expressed concern that there was no investigation by Children & Youth. Dauphin County Children & Youth made some calls in order to get the report. The coroner's report dated May 18, 2010 ruled that child's death was due to homicide from traumatic brain injury. Injuries included nine fresh bruises to the scalp that were circular, elliptical or irregular in shape, and a number of brain hemorrhages. The coroner's report had been provided to the

DA's office and Harrisburg Area Police in May, but CYS had not been notified.

Documents Reviewed and Individuals Interviewed:

DOCUMENTS REVIEWED:

Complete Dauphin CYS case records
[REDACTED]

Harrisburg Hospital ER record 01/22/2010

EMS report, 01/22/2010
[REDACTED]

Dauphin County Coroner's report

Harrisburg Area Police report of investigation, including parents' signed statements

INTERVIEWS:

[REDACTED] Dauphin CYS [REDACTED]
[REDACTED], Dauphin CYS [REDACTED]

Case Chronology:

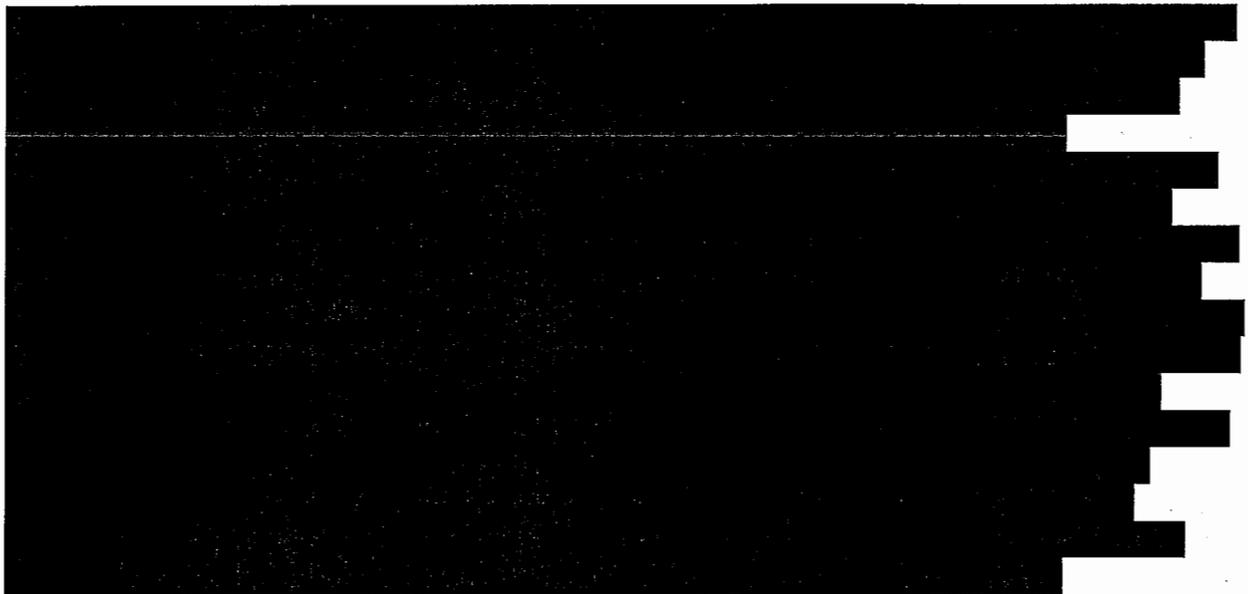
On October 14, 2010, [REDACTED] noted that on May 18, 2010 [REDACTED] had ruled the victim child's death a homicide. Dauphin County Children & Youth were unaware of the coroner's report which had been provided to the DA's office and Harrisburg City Police. They explored this new information, and initiated a [REDACTED] investigation on 10/14/2010, listing both parents as [REDACTED]. CYS visited the mother and sister at grandmother's home on 10/15/10, and saw the half-brother at school on the same date. A safety assessment was completed, and a safety plan developed which required another adult to be present with the children at all times. Both parents agreed to the safety plan, and a family friend and maternal grandmother agreed to provide the required supervision. Unscheduled home visits were made 10/25/10, 11/10/10 and 12/10/10. In each instance, the children were present with a parent and one of the other adult supervisors. There was no indication from the children or either parent of a threat of harm to the victim child's siblings. CYS checked the children's routine medical care [REDACTED]. No community providers expressed any concern about the care of the siblings.

Given the medical evidence and the fact that both parents were in a caregiver role, [REDACTED] as "[REDACTED]" CYS completed another full safety assessment on 12/10/10. The children were determined to be safe. A Risk Assessment was completed at the conclusion of the investigation. The overall risk for the two siblings was rated as Low. The CYS [REDACTED] reviewed the case at least nine times during the course of the investigation, in excess of the mandated reviews every 10 days.

Fatality Team meetings were held 11/19/10 and 12/10/10 which involved law

enforcement, medical experts, and CYS staff among others. The coroner described the pattern of brain injuries as consistent with an adult grabbing the infant's head and slamming it down on a hard surface with significant force. The various bruises appear to be thumb and fingerprints, while the brain hemorrhages were a result from the force used. The teams discussed the details of the events immediately preceding the child's death, and exactly who was providing care. There are discrepancies in the accounts provided by the parents, and unanswered questions including when father actually went to sleep after playing videogames, whether he cared for the child after mother fed her, whether the child remained in parent's upstairs bedroom or was taken to the 1st floor at some point, and other missing details. CYS deferred conducting additional interviews with parents so that the law enforcement investigation was not compromised. However, the polygraphs were not yet prepared or scheduled at the time of the 12/10/10 Fatality Review Team. The DA's office was critical of local law enforcement, which treated this case as accidental from the time of the incident on January 22, 2011, and did not collect or pursue evidence and statements at that time that would've been helpful in a criminal investigation.

No parenting deficits have been observed in either parent, except for the fatal inflicted injuries on the victim child. Neither parent was able to explain how the child was injured. The parents complied with the Agency's safety plan throughout the assessment. After administrative case review, the safety plan was vacated and the case was closed on December 12, 2010.



Status of law enforcement: The District Attorney's office took over the investigation of this case and assigned it to the County Detectives. There have been no arrests to date.

Previous CYS involvement:

Family was not known to Dauphin CYS prior to 01/22/10 referral at the time of the infant's death.

SERVICES PROVIDED:

CYS met with the family at the hospital on January 22, 2010 at the time of the victim child's death, and made a visit on that same date to parent's home to see the siblings and develop a safety plan. Although no allegation of [REDACTED] was made at this time, [REDACTED] notified local law enforcement and CYS because the cause of death was unknown. CYS observed the infant's bassinette as mother had described. Parents agreed to a safety plan that required another adult to be with the two siblings at all times. Mother and the siblings went to stay with maternal grandmother. Unannounced home visits were made to maternal grandmother's home on Sunday, 01/24/10, Wednesday 01/27/10, and Wednesday 02/16/10. The children were observed at each visit. The family was referred to [REDACTED] resources in the community. Additional home visits were conducted on 02/25/10 and 03/04/10 at the parents' home. The children were seen, and maternal aunt was at the home during each visit.

CYS obtained medical records for the victim child. These records verified parents' account that the infant remained in the hospital for a few days following her birth due to breathing problems. She had a well baby visit on 01/18/10 and they noted some wheezing in her breathing. The infant was to have returned for another check-up on 01/22/10. Mother was preparing for this appointment when she found the infant not breathing in her bassinette.

CYS had contact with the coroner's office and police. An autopsy was performed on 01/26/10, but results were pending. Harrisburg Area Police indicated that they had conducted initial interview of the parents on 01/22/10 but were waiting for the autopsy report to do follow-up. CYS participated on the County Child Death Review Team (a routine committee that reviews all child deaths in the county regardless of cause) on April 23, 2010. At that time, the coroner and pathologist voiced some disagreement regarding the child's cause of death. It was agreed upon by both the coroner and the pathologist that they would notify CYS [REDACTED]. Neither the coroner's office, the police nor the DA's office notified CYS of the outcome of the autopsy until October 14, 2010 when a comment was made to a 3rd party regarding the lack of an [REDACTED] investigation. The case, which had been investigated as a [REDACTED] referral, was closed at low risk on 03/04/10.

Circumstances of child's fatality:

On January 22, 2011, Dauphin CYS received a referral [REDACTED] regarding [REDACTED] and her children. The victim child, 10 days old, was deceased, and at Harrisburg Hospital. Child's mother reported feeding the child about 3 oz. of formula, swaddling her, and putting her back to bed at 5:30 a.m. in her bassinette. Mother got up around 11:20 a.m. to get ready for a doctor's appointment and noticed the child wasn't breathing. Mother called 911 and attempted CPR. Emergency responders and Emergency Room personnel were unable to revive the infant.

Current/most recent status of case:

To date, there has been no explanation from either parent regarding the victim child's injuries. Parents complied with the Agency's safety plan throughout the assessment. After administrative case review, the safety plan was vacated and the case was closed on December 12, 2010. [REDACTED]

[REDACTED]

The District Attorney's office took over the investigation of this case and assigned it to the County Detectives. The investigation is continuing. There have been no arrests to date.

Services to children and family:

[REDACTED]

[REDACTED]

Highmark Caring Place (center for [REDACTED] children & their families)

[REDACTED]

Kaplan School nurse's aide certificate program (mother)

[REDACTED]

Hershey Medical Center (mother's pregnancy and childbirth)

County strengths and deficiencies as identified by the County's near fatality report:

An Act 33 meeting was held November 19, 2010. The local police, DA office, coroner's office, CYS and Central Region were represented at the meeting. The County Death Review Team, which includes a broad cross-section of community medical, legal, and social service professionals met on December 10, 2010.

STRENGTHS:

- Children & Youth responded immediately to both reports (January and September) and established safety plans for the siblings within 24 hours.
- Children & Youth safety plans utilized the family's own resources, preventing the need for out-of-home placement for the siblings.
- The County district attorneys office and CYS have a strong cooperative relationship (except for the oversight noted regarding the notice of the coroner's report) and attempt to work jointly on the child [REDACTED]/criminal investigations.

DEFICIENCIES:

- The [REDACTED] investigation was delayed due to lack of notification of the final autopsy report.
- The criminal investigation was incomplete due to local law enforcement's initial conclusion that the child's death was accidental. Insufficient evidence was gathered and insufficient interviews were conducted. Parents' polygraphs were not prioritized and did not occur until at least six months following the May interviews.

County recommendations for changes at the local (County or State) levels as identified in County's near fatality report:

- Recommended that initial investigations be conducted on the presumption of foul play. Local police conducted initial interviews and believed parents to be credible and appropriate. When homicide ruling was made some months later, local

police investigation was not aggressive or timely due to their initial assessment that there was no indication of foul play.

- The coroner's office and/or DA's office should notify ChildLine and Dauphin County CYC immediately when an autopsy report determines a child has been abused.
- The county CYC was constricted by the regulation that limits a [REDACTED] investigation to 60 days. The CYC agency made extensive efforts to cooperate with law enforcement and delayed re-interviewing alleged perpetrators, or carefully refrained from sharing specific forensic information in order to not compromise the law enforcement investigation.

Central Region findings:

- Mandated reporter training should be made available to the medical examiner and coroner's offices on a routine basis.

[REDACTED] It is critical that complete identifying information be gathered for [REDACTED] reports. [REDACTED]

- Counties should comply with the law in sharing case information with other children & youth agencies in the interest of child protection.
- Minutes are not kept from the MDT meetings held in the DA's office. The Act 33 MDT does not include sufficiently broad representation of disciplines

Statutory and Regulatory Compliance Issues:

CPSL 6365 (d)(1) Act 33 meeting, due on or before day 31 following oral report of suspected child abuse, was held on day 37. The meeting did not include "individuals who are broadly representative of the county who have expertise in the prevention and treatment of child abuse." The Child Death Review Team meeting 12/10/2010 (55 days following the oral report) did include those persons. A cite for this violation will be included in the agency's annual licensing inspection report.