COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF

Ashley Brady

BORN: 11/03/2011
DATE OF DEATH: 12/31/2011

FAMILY NOT KNOWN TO CYS AGENCY

REPORT FINALIZED ON: 03/28/2013

This report is confidential under the provisions of the Child Protective Services Law and cannot be released. (23 PA. C.S. § 6340)
Unauthorized release is prohibited under penalty of law. (23 Pa. C.S. § 6349(b))

Reason for Review

Senate Bill No. 1147, now known as Act 33 was signed 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.

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. Dauphin County has convened a review team in accordance with Act 33 of 2008 related to this report. Team meetings were held on February 1, 2012 and February 24, 2012.

Family Constellation:

Name	Relationship	Date of Birth
Ashley Brady	Victim Child	11/03/2011
[redacted]	Mother	[redacted]/1992
[redacted]	Father	[redacted]/1992

Notification of Fatality/Near Fatality

On Tuesday, January 3, 2012 Dauphin CYS was notified by the [redacted] that there was a suspicious death. An autopsy completed on this date (Monday being the New Year's Day holiday) and revealed multiple healing rib fractures. Because of the stage of healing, the [redacted] could not have been caused by attempts to perform CPR during the child's medical crisis on December 31, 2011.

In the early morning of December 31, 2011, the victim child was found at home unresponsive and was later pronounced dead at the hospital. An autopsy revealed multiple healing fractures [redacted]. The degree of healing is similar, likely several weeks in age.

Infant was seen at the ER on November 25, 2011 when father was concerned that she was not eating and was "gassy." [redacted] was provided and over-the-counter remedies recommended. Child was x-rayed during this visit [redacted]. Parents took the infant to the ER on December 25, 2011 because she had a "runny nose and is fussy." She was not admitted. The hospital counseled parents about using the emergency department for genuine emergencies. On December 31, 2011, father checked on the baby and "knew something wasn't right." Mother called 911 at 1:23 a.m. on December 31, 2011 and police responded. When they arrived, child was not breathing and father was administering CPR, but was "pretty rough". First responders took over and administered CPR but could not detect a pulse. Child was taken to Harrisburg Hospital where she was pronounced dead at 2:20 a.m.

The report was [redacted] following the discovery of the [redacted]. Father was said to be the child's sole caretaker while mother worked 12-hour shifts at her job.

Summary of DPW Child (Near) Fatality Review Activities:

Reviewed entire child and family files maintained by Dauphin County Children & Youth Services (CYS)
Attended Act 33 Multi-disciplinary team meetings held February 1 and 24, 2012
Interviewed investigating Dauphin CYS caseworker

Reviewed victim child's medical files
Reviewed coroner's report, police reports
Reviewed victim child's medical files

Summary of Services to the Family

Children and Youth involvement prior to Incident:

None

Circumstances of child's near fatality and related case activity:

INVESTIGATION: In the early morning of December 31, 2012, the victim child was found at home unresponsive and was later pronounced dead at the hospital. [redacted]

Infant was seen at the ER on November 25, 2011 when father was concerned that she was not eating and was "gassy." [redacted] was provided and over-the-counter remedies recommended. Child was x-rayed during this visit [redacted]. Parents took the infant to the ER on December 25, 2011 because she had a "runny nose and is fussy." She was not admitted. The hospital counseled parents about using the emergency department for genuine emergencies. On December 31, 2011, father checked on the baby and "knew something wasn't right." Mother called 911 at 1:23 a.m. on December 31, 2011 and police responded. When they arrived, child was not breathing and father was administering CPR, but was "pretty rough". First responders took over and administered CPR but could not detect a pulse. Child was taken to Harrisburg Hospital where she was pronounced dead at 2:20 a.m.

A skeletal survey was done and child was discovered to have [redacted]. These were not due to the CPR attempts because [redacted]. The autopsy revealed a number of [redacted] The body temperature of the victim child indicated that the death had occurred a number of hours prior to the parents' 911 call.

[redacted] at the time of child's death, father was unemployed and mother worked 10-12 hour shifts beginning at 7:00 a.m. Father cared for the child while mother worked. The family lived in an efficiency apartment which was being heated using the oven set on the broiler setting. [redacted]

[redacted] asked CYS not to contact the family initially, and when they attempted contact in mid-February, CYS was unsuccessful in locating or speaking with parents. When a report of the [redacted] was made available to CYS, they learned that there had been other caregivers in addition to the father. The father [redacted] he had worked out of state for 2-3 weeks in December and that maternal grandparents had assisted with the child's care during that time. The names and contact information for the grandparents were not included in the report and were not provided to CYS.

The Harrisburg Hospital declined to provide records to CYS without parents' release, despite Child Protective Service Law (CPSL) provisions. CYS eventually got hospital records from the coroners' office.

The [redacted] was filed on March 2, 2012 as [redacted].

Mother requested a copy of the death certificate, which listed the cause of death as homicide, in April 2012. This triggered father's arrest on homicide charges. Neither parent responded to

CYS' repeated attempts to contact [redacted]. At present, Father has an attorney and is not available for interviews due to the gravity of the charges.

Current/most recent status of case:
Father was arrested on April 22, 2012 and charged with Criminal Homicide, Aggravated Assault & Endangering the Welfare of Children. He is denied bail. His preliminary hearing has been continued twice and is scheduled for July 2, 2012.

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

County Strengths:

County Weaknesses:

- Harrisburg City Police asked CYS not to notify parents about the suspected [redacted] until about six weeks following the child's death. [redacted] failed to inform CYS of the information they had regarding their own interviews with the parents. This particular police jurisdiction has historically failed to coordinate investigations with CYS, which impairs CYS' ability to do comprehensive and timely investigations.
- Harrisburg Hospital refused to release medical records to CYS despite the provisions of the Child Protective Services Law permitting such release without parental permission. Attempts to rectify this situation by having the hospital and CYS attorneys communicate have thus far been nonproductive.

County recommendations for changes at the local (County or State) levels as identified in County's near fatality report:
None made

Department of Public Welfare Findings:

County Strengths:

- The county CYS was notified promptly as soon as it was known that the child's' death was suspicious of abuse.
- CYS made repeated attempts to contact local police in an effort to move the investigation forward.
- Once cleared by Law Enforcement (LEO), CYS made repeated attempts to contact with parents, including unannounced visits and scheduled home visits.
- The county Child Death Review Team is a comprehensive, multi-disciplinary group that meets frequently. The team is well-established and discusses cases in depth.

County Weaknesses:

- The county's Child Death Review Team, which conducts the Act 33 meetings, produces minutes, but the minutes do not outline county strengths and weaknesses or recommendations made by the team. The Act 33 team does not prepare a Fatality report as required by the CPSL.
- Harrisburg City Police asked CYS not to notify parents about the suspected [redacted] until about six weeks following the child's death. [redacted] failed to inform CYS of the information they had regarding their own interviews with the parents. This particular police jurisdiction has historically failed to coordinate investigations with CYS, which impairs CYS' ability to do comprehensive and timely investigations.

Harrisburg Hospital declined to release medical records to CYS despite the provisions of the Child Protective Services Law permitting such release without parental permission. This

problem has arisen on occasion when the Hospital is not the reporting source for the [redacted] report. CYS has made requests in person with more success, and plans to have the CYS attorney contact the hospital attorney if future issues arise.

Statutory and Regulatory Compliance Issues:

A License Inspection Summary (LIS) was issued to the county agency as a Risk Assessment was not completed at the conclusion of the [redacted] investigation per 3490.321(h)(i).