



Elaine C. Bobick
Regional Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF CHILDREN AND FAMILY SERVICES
WESTERN REGION

(412) 565-5728
Fax: (412) 565-7808

11 Stanwix Street, Room 260
Pittsburgh, Pennsylvania 15222

REPORT ON THE FATALITY OF:

Cooper Bess

DATE OF BIRTH: February 1, 2010
DATE OF DEATH: October 13, 2011

The family was not known to Erie County CYS

REPORT FINALIZED ON: March 26, 2012

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 Child Line 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 Child Line. Erie County has convened a review team in accordance with Act 33 of 2008 related to this report. If the county agency has not convened a review team, provide an explanation in this section.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Cooper Bess	Deceased child	02/01/2010
██████████	mother	██████████ 1974
██████████	father	██████████ 1974
██████████	sibling	██████████ 2008
██████████	sibling	██████████ 2011
██████████	caretaker/babysitter	██████████ 1972

Notification of Child (Near) Fatality:

Erie County Children and Youth Services received a report from a case manager from ██████████ on 10/11/2011; the reporter informed the agency that on the morning of 10/11 Cooper Bess was in the care of a babysitter when she realized he was missing. After searching for him for approximately ½ hour, she contacted 911 at 9:16am. The Erie County Pennsylvania State Police (hereafter referred to as PSP) troop E responded to the home to assist in the search. At 10:20am Cooper was discovered in a pond approximately 400-500 yards from the babysitter's home. The child was not breathing and CPR was initiated at the scene. A pulse was found several times and the child was transported to ██████████ ██████████ in Erie around 10:30 am. The physician who examined the child stated that the child's prognosis was grim, and certified the child to be in critical condition as the result of alleged lack of supervision. The report was registered for ██████████ and was processed as a near fatality. Cooper was transported via life flight to ██████████ and admitted to ██████████ ██████████ at 4:30 pm. It was not known at the time if there were other children in the family.

A supplemental report was received on 10/18/11 which upgraded the report to a fatality as Cooper died on 10/13/11 [REDACTED] secondary to drowning. The supplemental report also stated that the child was attending a day care called [REDACTED] that was operating illegally as the provider was a [REDACTED] which means she could accept payment for 3 unrelated children in her care. At the time of the incident, the babysitter had 5 unrelated children in her care. The report alleged that the child wandered away from the daycare (time unspecified); at 9:16 am the babysitter contacted the police as she was unable to locate the child. At 10:20 am the child was found in a pond by a police officer. The pond was at least 1,600 feet from the residence. It was unknown how the child got out of the home. The babysitter allegedly had to take a 7-8 year old child to the bus stop at some point in the morning. The RS believed that there was a lack of supervision, leading to the child getting out of the house and drowning. It was reported that the PSP were conducting an investigation.

Summary of DPW Child (Near) Fatality Review Activities:

The Department of Public Welfare's Western Region staff attended the Erie County Office of Children and Youth multi-disciplinary team meetings on November 17th and December 6, 2011. The Department obtained and reviewed all case record information from the time of the 10/11/2011 initial report, which includes: initial referral information; the supplemental report dated 10/18/11; the risk assessment; in-home safety assessment worksheet; all contact summaries; the referral to law enforcement; medical records; supervisory log and intake supervisory review form; [REDACTED] newspaper articles; and, the child death review team meeting minutes.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

There was no previous involvement with the [REDACTED] family.

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

Upon receipt of the report on 10/11/2011, Erie County contacted the [REDACTED] [REDACTED] to obtain information on the other children in the care of [REDACTED]. The agency also contacted the reporting source to obtain additional information. Allegheny County was then contacted to request a courtesy visit of the family as Cooper was at Children's Hospital of Pittsburgh. The agency completed the Report of [REDACTED] to the PSP.

On 10/12/2011, [REDACTED] contacted Erie County to report that Cooper was not expected to survive; that he was a well grown 20 month old but he had

bruising on both eye lids and some abrasions as well. He also had a fat lip and abrasions on the lips and both ears, and normal bruising to the rest of his body. Possible causes of these bruises were not identified. She reported that Cooper had [REDACTED] but that this was typical as he was dying. [REDACTED] also reported that the parents were defending the babysitter. The hospital had no concerns with the family and the parents were appropriate. The hospital did not plan to have x-rays taken, as it was believed there would be an autopsy upon the child's death. [REDACTED] also reported that the family had a three year old, and a five month old.

On 10/12/2011, Erie County contacted the PSP investigating officer who was handling the law enforcement investigation. In addition to the 3 [REDACTED] children, the babysitter was also caring for a 13 month old and a 4 year old.

The caseworker also followed up with Allegheny County Children, Youth and Family Services and confirmed that a caseworker did make contact with the family at the hospital on 10/11/2011. That caseworker spoke to the hospital social worker who reported that the physician interviewed the parents. Specific information regarding this contact and an update on Cooper's condition was in a report completed by Allegheny County and received by Erie County on 10/17/2011. Cooper's condition was reported as "not stable enough for a head [REDACTED]" and that his prognosis was "grim". His 2 siblings were reported to be with their maternal grandmother. The report included a statement that on the day of the drowning Cooper was with his babysitter and she was watching all 3 of the children, and while she was changing a diaper, Cooper escaped. It was also noted that he had a "history of escaping". Cooper was reportedly found by the police "a quarter mile from the home in a pond, face down", and that there was "bruising" to his face. It was also reported that the father has known the babysitter since he was a child.

The Erie County caseworker had a discussion with the PSP Trooper assigned to the investigation on 10/12/11 regarding Cooper's older sibling, [REDACTED] about her whereabouts and the need to schedule a forensic interview with her. Later that day, the trooper contacted the caseworker to inform her that the children were with a different relative as the maternal grand mother was at the hospital. The trooper spoke to the grandfather who told the trooper that an interview with [REDACTED] could not happen as there was too much going on right now. The parents refused for [REDACTED] to have a forensic interview. [REDACTED] had determined that Cooper had no brain functioning on this date.

Erie County was notified that Cooper passed away on 10/13/2011. The Erie County supervisor reported to the Department that there was little information to date regarding the criminal investigation, as the investigating trooper was still trying to determine the time-line of events. The parent's were continuing to support the babysitter.

On 10/17/2011, Erie County received the documentation from Allegheny County OCYF regarding the courtesy interviews completed at [REDACTED] on 10/11/2011 as reported above.

On 10/18/2011, a supplemental report was received by child line which included the information as presented in the Notification of Child Fatality section. Erie County attempted to make contact with the DA and the LEO for an update. Later that day, there was contact made with an assistant DA who reported that the babysitter told the PSP trooper that she was on the phone making calls to try to win a radio station prize and was drinking coffee at the time of the incident. He confirmed the criminal investigation was ongoing. There was also conflicting information regarding whether both of the siblings were at the babysitters that day.

On 10/24/2011, the agency sent a letter to [REDACTED] asking for them to contact the agency regarding the referral. [REDACTED] left a message for the caseworker on 10/26/2011 and an appointment was scheduled for a home visit with the family for 10/28/2011.

On 10/28/2011, the caseworker met with the [REDACTED] family in their home. The parents reported that Cooper was a runner and that he ran a lot; he could get through doors, locked or not, and was very quick. They reported that there was a gate that no one thought Cooper could get through, but he did. The caseworker spoke to the family about [REDACTED] for [REDACTED] for the family. The family politely refused to sign any releases, and reported that they wanted to move on and put the situation behind them. The parents did not want [REDACTED] to have a forensic interview. A preliminary safety assessment was completed as a result of this visit and [REDACTED] and [REDACTED] were deemed to be safe in the care of their parents.

On 11/17/2011, the agency conducted a child death review team meeting. There was a discussion regarding the fact that the agency had not been able to interview the babysitter, and what had been reported by other parties who actually spoke to her showed a discrepancy in what she had stated she was doing at the time that Cooper left the home. It was suggested, by the Departments regional program representative, that the caseworker and another Erie County staff completed an unannounced home visit at the babysitter's to ensure the safety of the children as it had been reported that the [REDACTED] were continuing to allow [REDACTED] to baby-sit their children. It was also necessary to obtain her account of the events and to witness the terrain. The agency had not been able to obtain a copy of the PSP report to date, so it was suggested that the PSP Trooper be invited to participate at the next meeting by phone to provide an update regarding the criminal investigation. A follow-up meeting was scheduled for 12/06/2011.

On 11/23/2011, the agency caseworker and a supervisor went to the baby sitter's home. She relayed the following information regarding the date of the incident: She was caring for 3 children that day and she remembered that the last child was dropped off and the parent left around 8:51; she stated that it was earlier in the morning when she tried to win the radio contest and that she was keeping an eye on Cooper at that time; It was a nice day so she had the sliding glass door open so that the children could go out onto the porch and that a gate was in place blocking off the steps; the children wanted to watch a movie so she went into the back room to get a cord for the DVD player and after returning, she realized that she could not find Cooper; she then ran outside and saw that the gate was still in place so she looked around the house and started getting the other 2 children ready to go look for him outside; she contacted the parents, a neighbor to assist in the search and called 911 at about 9:15. When the police arrived, they began checking the inside of the house as it was believed that Cooper may have been hiding in the house since the gate was intact. All parties were called into the home and the search outside was halted in the event the search dogs needed to be utilized. Once it was determined that Cooper was not inside the house, the police began searching outside on the property. Cooper was discovered in the pond and it is believed that he crawled up on a gliding sofa that is on the porch and crawled over the railing where he dropped 3-4 feet onto the ground. [REDACTED] also stated that she knew that Cooper was a "runner", but learned more details from his parents after this incident. There had been no previous incidents of his getting out. The Erie CYS staff went outside and noted that there were bushes that Cooper could have crawled under which led to the pasture where the horses are. It is believed that Cooper chased the horses and wandered to the pond.

On 12/05/2012, the caseworker completed a second home visit at the [REDACTED] residence to discuss the allegations and to complete a monthly home visit to assure [REDACTED] and [REDACTED] safety. The parents reported that they were continuing to utilize [REDACTED] to care for [REDACTED] and [REDACTED] and they had no concerns for her supervision and they believe their children are safe in her care. The maternal grandparents were also assisting in watching the children at times. The caseworker offered services of [REDACTED] to the family but the parents stated that they have a wonderful support system of family and friends, and did not believe CYS services were necessary at this time. The children were visiting with their maternal grandparents so the caseworker scheduled to come back to the home to see the children on 12/07/2011. The caseworker also contacted the PSP Trooper and left a message on this date to see if a time-frame for the events had been established.

On 12/06/2011, the agency conducted a follow-up child death team meeting in which there was a discussion regarding the specific information obtained when [REDACTED] was interviewed. The PSP Trooper did not participate in the meeting and the agency had not been successful in obtaining a copy of the police report.

Criminal charges were not filed and the law enforcement investigation was closed. The following recommendations were made at this meeting:

- The caseworker was to visit with the parents in their home to gather an update in an effort to establish a time-line of events; including the routine for taking the children to [REDACTED] home. To establish if there were previous incidents in which Cooper escaped while in [REDACTED] care, and to discuss their thought process in allowing her to continue babysitting their other children. It was suggested that the caseworker again discuss with the parents the need to schedule a forensic for [REDACTED].

On 12/07/2011, the caseworker visited the family home and saw [REDACTED] and [REDACTED]. The caseworker documented that the children were happy and well cared for and no concerns were identified. The parents declined that [REDACTED] participate in a forensic, as they believe that this was a tragic accident, and they want to move past this. The parents did not report any previous incidents of Cooper running while in [REDACTED] care. As a result of this visit, the case closure safety assessment was completed on 12/08/2011 and [REDACTED] and [REDACTED] were deemed to be safe in the care of their parents.

A risk assessment was completed by the caseworker dated 12/06/2011, with the overall risk and severity for [REDACTED] and [REDACTED] rated as Low.

The [REDACTED] investigation Report, [REDACTED] was submitted to [REDACTED] on 12/06/2011 with the [REDACTED] determination of [REDACTED] as the county determined that there was not substantial evidence to support that there was lack of supervision on [REDACTED] part. Cooper's fatality was determined to be an accident and to not be a result of neglect.

The intake supervisor maintained supervisory reviews and documented her case reviews with the caseworker on 10/11, 10/13, 10/18, 10/25, 11/08, 11/22, 12/06, 12/7, 12/8/2011.

The documentation was reviewed by the supervisor and approved for case closing on 12/13/2011.

Allegheny County's Coroner's office determined that Cooper death was an accident and the death certificate was issued without an autopsy being performed.

Current Case Status:

The case was closed by Erie County CYC on 12/13/2011.

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

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of [REDACTED] 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 [REDACTED]. Erie County has convened a review team in accordance with Act 33 of 2008 related to this report. If the county agency has not convened a review team, provide an explanation in this section.

Strengths:

- The team determined that Erie County staff did an excellent job in going above and beyond to gather the necessary information to make an accurate status determination. The caseworker and supervisors handled the situation well, given the circumstances of this case.

Deficiencies:

- There was a lack of cooperation by the Pennsylvania State Police in providing information to the county agency regarding the criminal investigation. Neither police nor the District Attorney's office submitted a report describing the criminal investigation to the agency.
- The county believes the requirement established by the Department that a child death review meeting needs to occur on day 31 if a status determination on the CPS investigation is not made within 30 days is unreasonable. The county believes that in most cases, 30 days is not enough time to gather all of the necessary information regarding cases of near fatalities or fatalities.

Recommendations for Change at the Local Level:

- Erie County plans to utilize a team approach in the future when caseworkers need to interview grieving families to complete investigations.
- The agency also plans to offer more training opportunities for caseworkers and supervisors regarding how to effectively deal with grieving families.
- The agency would also like to work with the PSP to develop joint training on how to improve communication and procedures in child fatality cases.
- The agency needs to reach out to local law enforcement to reinforce the importance of their collaboration with the county regarding cases that meet the Act 33 requirement, and the importance of their attendance at the child death review meetings.

Recommendations for Change at the State Level:

- Erie County is asking the Department to consider issuing a directive to law enforcement agencies, specifically the Pennsylvania State Police that they extend their cooperation and provide reports to county Children and Youth Agencies when investigating child fatalities and near fatalities.

- There is a need to reach out to the PSP and District Attorneys to reinforce the importance of their collaboration with the county regarding cases that meet the Act 33 requirements.

Department Review of County Internal Report:

The Department is in agreement with the Erie County findings as detailed above.

Department of Public Welfare Findings:

County Strengths:

- Erie County Children and Youth Services has an established child death review team that has been consistent in making diligent efforts to comply with the Department time-frame requirements for having a child death review team meeting.
- The agency made numerous attempts to contact and corroborate with law enforcement regarding their criminal investigation findings but were met with resistance as PSP nor would the DA's office provide a copy of the LEO report to the agency.
- The agency decided to complete an unannounced home visit at [REDACTED] residence to gather details from her perspective in an effort to establish a time-line of events to assist in making a status determination finding. The decision was made at the team meeting on 11/17/2011, that given the time-constraints for a [REDACTED] investigation, the agency needed to make an effort to interview [REDACTED]. The decision was made for a supervisor to go with the caseworker to complete this home visit to ensure a successful contact in gathering the details.

County Weaknesses:

- Erie County has not been able to successfully engage law enforcement in their area to participate in the child near fatality and fatality review meetings. In this particular case, the PSP and DA's lack of cooperation in providing details of the investigation, including failing to share a copy of the report with Erie County staff impeded Erie County in moving forward with their investigation.
- 3490.61 states that the agency supervisor shall review each [REDACTED] report which is under investigation on a regular and on-going basis to ensure that the level of services are consistent with the level of risk to the children, to determine the safety of the child and the progress made toward reaching a status determination. The log utilized by Erie County is difficult to follow and the Department believes the format is confusing as it contains yes and no questions, which do not appear to comply with the details of the regulatory requirements.

Statutory and Regulatory Areas of Non-Compliance:

- The supervisory logs were maintained throughout the assessment period however, the logs were not maintained according to the 10 day time-frame in the above 3490 regulations. The Department is not issuing a licensing citation as the logs were maintained and the safety of the children and the service provided to the family was not compromised as a result of the entries being documented late.

Department of Public Welfare Recommendations:

There are 2 systemic issue identified with this review. The first is the fact that the local police, the District Attorney, and PSP do not always cooperate in their collaboration effort to work with Erie County. There is also lack of cooperation from law enforcement officials in attending the child near fatality and fatality meetings as mandated for the county during such case investigations. Erie County needs to continue to make efforts to engage the law enforcement officials in the area and reinforce the importance of having their input during the course of the investigation and their attendance at the child review meetings.

The Department recommends that the agency follow through in developing a curriculum for training for both county children and youth staff and PSP investigators regarding the Act 33 process requirements, and consider expanding this opportunity to other local LEO's.

The second identified systemic issue is the supervisory review log that the agency continues to utilize. There have been on-going discussions regarding the Department's concern that the logs are difficult to follow and that the format is confusing as it does not seem to allow for the details required per the 3490.61 regulation.

Erie County's concern regarding the requirement to have a meeting on day 31 if a status determination is not made on the CPSL investigation within 30 days has been an on-going concern of the agency. In many cases, this does not allow enough time for all of the information to be gathered, especially when there is a coinciding LEO investigation. The agency will schedule an initial review on day 31 to present whatever information is available at this point however, in almost every Act 33 case in Erie County, because of the lack of information available at this point in the investigation; a second meeting must be convened. Since the [REDACTED] gives a county 60 days to complete a [REDACTED] investigation, the Department should consider changing the required mandated time-frame for the county to schedule the review to expedite the process and avoid the team needing to convene 2 times, instead of once.