



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF

Eviannah Toro

Date of Birth: 03/01/2013

Date of Death: 01/06/2014

Date of Oral Report: 01/07/2014

FAMILY KNOWN TO:

York County Children, Youth, and Families

REPORT FINALIZED ON:

10/20/2014

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(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. York 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>
Toro, Eviannah	Victim Child	03/01/2013
[REDACTED]	Mother	[REDACTED] 1991
[REDACTED]	Father	[REDACTED] 1990
[REDACTED]	Step-Sibling	[REDACTED] 2010
[REDACTED]	Household Member	[REDACTED] 1962
[REDACTED]	Household Member	Unknown
[REDACTED]	Household Member	Unknown
[REDACTED]	Household Member	12 years
[REDACTED]	Household Member	7 years
[REDACTED]	Household Member	Unknown
[REDACTED]	Maternal Grandmother	[REDACTED] 1959
[REDACTED]	Maternal Step-Grandfather	Unknown
[REDACTED]	Maternal Uncle	17 years

Notification of Child Near Fatality:

The child was brought to the hospital on January 5, 2014 and was non-responsive. She was pronounced dead at 2:09am on January 6, 2014.

York County Children and Youth Services (CYS) received a request from the coroner on January 6, 2014 regarding this child, but were not contacted by the [REDACTED] regarding the child until January 7, 2014. [REDACTED]

[REDACTED] The child fatality was [REDACTED] by medical staff at York Hospital.

Summary of DPW Child Fatality Review Activities:

The Central Region Office of Children, Youth, and Families obtained and reviewed all current and past case records pertaining to the Victim Child and her family. Medical records were also reviewed. Conversations and interviews were conducted with the

Caseworker [REDACTED] Supervisor [REDACTED], and Quality Specialist [REDACTED] throughout involvement but specifically on March 6, 2014, August 28, 2014, and September 3, 2014. The Regional Office also participated in the County Act 33 Fatality Review Team meeting on January 31, 2014.

Children and Youth Involvement prior to Incident:

On June 17, 2013, the agency received a report [REDACTED] regarding the victim child. The child had a lump on the left side of her head. The mother did seek medical treatment. There was no alleged perpetrator identified due to the number of household members at the time of the report. The agency conducted interviews with the mother, father, babysitters, and some household members. The mother and father were living together at this time, but chose to live in different homes by the end of the investigation. There was apparently also an incident [REDACTED] where the child [REDACTED] and the father had to perform CPR. The child went back to normal so medical attention was not sought immediately. When the child was taken to the doctor, the medical staff did not have [REDACTED]. The case was [REDACTED] on July 23, 2013, and closed with the agency.

Circumstances of Child Fatality and Related Case Activity:

The current incident apparently occurred on 1/05/14, but York CYS was not contacted by the [REDACTED] about the report until 1/07/14.

The child had been experiencing congestion and a cough and was seen by the pediatrician on January 3, 2014. The father stated that at 8:30pm on January 4, 2014, the mother gave the child a bottle, [REDACTED], and some Vick's vapor rub, and put her to bed. At 9:30pm, the other child in the home was put to bed by the father. The victim child was moving in her bed at that time. The father and mother had a few drinks and were playing some video games. The mother ran out to a gas station for ten minutes at one time. At 1:00am the father went to bed and mother went to check on the victim child. The father heard the mother stating that something was wrong. The baby was face down in the bed and was limp and unresponsive. The mother reported she had placed the baby on her side when she put her down. An ambulance was called to the home. The father stated that there was red mucous coming from the child's mouth when he took her from the mother. The father followed directions from the 911 operator to conduct chest compressions. The child threw up on the bed. The child was taken to the hospital by ambulance and pronounced dead at the hospital.

An autopsy was conducted on 1/06/14 and it was noted that the autopsy was pending. During the autopsy, [REDACTED]

[REDACTED] Report was registered as a fatality.

The mother and father do not live together, but apparently did family things together and stayed at each other's homes occasionally. This incident occurred at the father's home in [REDACTED]. There is another child in the family. He remained with the paternal grandmother throughout the investigation under a safety plan that the grandmother would supervise contact with the parents.

The parents and household members were questioned [REDACTED]. The story did not change [REDACTED]. Family members were not suspicious of the mother or father in regards to care of the victim child.

The autopsy for the child was returned on 3/17/14 with the cause and manner of death ruled as undetermined, though asphyxiation could not be ruled out. [REDACTED] Police closed their case without any charges.

The agency filed the [REDACTED] with ChildLine on 3/06/14 with a status of [REDACTED]. On 3/27/14, the agency filed an updated [REDACTED] with a status of [REDACTED] for all alleged perpetrators as the cause of death came back undetermined and the alleged perpetrators denied any abuse.

The case was closed with the agency. During the course of the investigation, the Paternal Grandmother had obtained custody of the sibling of the victim child. At the conclusion of the investigation, she returned custody to the father, however the child remained living with her.

Current Case Status:

No relevant updates since the case was closed in March 2014.

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

A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on January 31, 2014 at the York Hospital. The team was comprised of local CYS professionals, medical professionals, law enforcement, and regional staff.

- **Strengths:**
The team felt that the agency handled the current [REDACTED] investigation well and provided information to all parties involved. The agency maintained consistent communication with the hospitals and medical professionals throughout the case.
- **Deficiencies:**
None were noted by the team in regards to the handling of the case by the agency.
- **Recommendations for Change at the Local Level:**
No recommendations were made.

- Recommendations for Change at the State Level:
None noted.

Department Review of County Internal Report:

York County CYC provided a report on the Near Fatality of the Victim Child to the Regional Office on February 25, 2014. The report contained all required information and a summary of the findings of the agency Act 33 review team meeting. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on February 25, 2014.

Department of Public Welfare Findings:

- County Strengths:
 - County response to information received was urgent and thorough during the [REDACTED] investigation.
 - The [REDACTED] Investigation was completed in a timely manner and included full collaboration with local police and medical professionals.
 - The MDT was held in an immediate time frame and included professionals that could provide valuable input regarding the child and family.
- County Weaknesses:
 - In the June 2013 investigation, the agency did not complete interviews with every household member that may have been in a caretaking role, or observed any concerns in the home, specifically two household members. While the injuries did not rise to the level of [REDACTED], all members should have been interviewed prior to making a status determination.
- Statutory and Regulatory Areas of Non-Compliance:
 - Review of the Investigative file found that a Safety Assessment Worksheet was not completed at the conclusion of the investigation. A citation will be issued to the agency as a result of this finding and they will be expected to submit a plan of correction to assure that this is completed in subsequent investigations.

Department of Public Welfare Recommendations:

The agency should attempt to interview all household members that may have acted as a caregiver or observed any interactions with the children and the alleged perpetrators. This will allow for a more thorough, concrete investigation, and assure that the need for further services is not warranted.