



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Maya Wiederhold

Date of Birth: 1/24/14

Date of Death: 5/17/14

Date of Oral Report: 5/21/14

FAMILY NOT KNOWN TO:

Schuylkill County CYS

REPORT FINALIZED ON:

12/10/2014

07/01/2016 Amended

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, 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. Schuylkill County 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>
Maya Wiederhold	Child Victim (CV)	01/24/14
[REDACTED]	Sibling	[REDACTED]/13
[REDACTED]	Mother	[REDACTED]/93
[REDACTED]	Father of CV	[REDACTED]/90
[REDACTED]	Father of Sibling*	[REDACTED]/92

Notification of Child Fatality:

On 5/17/14 Schuylkill County Children and Youth Services (CYS) received a call from the [REDACTED] Police. Police responded to home of CV's parents due to concerns with an unresponsive infant, CV. CV was pronounced deceased, police expressed concern for illegal drug paraphernalia found in the home and concern for circumstances surrounding CV's death.

On 5/21/14 Schuylkill County CYS was informed by the [REDACTED] Police CV's parents both tested positive for heroin on the evening of CV's death and preliminary autopsy results determined CV's cause of death to be "suffocation" due to "heavy lungs." Police reported that CV was allegedly placed, on her back, for a nap on the parent's bed but located several hours later on her side/faced down on the bed. The parents' stories vacillated in regard to who placed CV down for nap.

Summary of DHS Child Fatality Review Activities:

The Office of Children, Youth and Families, Northeast Regional Office (NERO) immediately contacted Schuylkill County CYS for the status of the case. The family was not known to Schuylkill County CYS. Information was given and a preliminary report was completed by NERO. On 6/20/14, the NERO attended the Act 33 meeting for the CV. Interviews with all parties, as well as evidence and findings were discussed. The [REDACTED] record was also reviewed.

Children and Youth Involvement Prior to Incident:

The family was not known to Schuylkill County CYS prior to CV's death.

Circumstances of Child Fatality and Related Case Activity:

This case initially came to the attention of CYS as a [REDACTED]. The police responded to the home on the night of the incident, and although the case was not [REDACTED]

[REDACTED]

On 5/21/14 [REDACTED] Supervisor, [REDACTED], obtained information from the [REDACTED] Police regarding interviews with CV's parents the night of CV's death. CV was reportedly fed 4 oz. of Similac around 2:00/3:00 PM on 5/17/14. CV was put for nap around 3:00/3:30 PM and found deceased at 7:30 PM by mother. CV was being held by mother when police responded to the home. The family home did not have a phone but CV's father ran through the apartment complex knocking on doors requesting neighbors call "911." Two different tenants telephoned "911" to report a disturbance in the complex.

CV's parents were reportedly watching movies while CV napped. The paternal uncle visited the home while CV was asleep to ask if CV's father wanted to go out for a few hours. CV's mother became upset with the request and went into the parents' bedroom. CV's mother noticed CV was not breathing. CV's mother screamed for CV's father and paternal uncle. After noticing CV was not breathing, CV's father went knocking door to door and the paternal uncle went running down the street toward a local mini market to use the public phone. CV's father was also seen at the dumpster of the apartment complex where he was attempting to dispose of drug paraphernalia. CV's father admitted to using heroin the day prior and CV's mother admitted to using heroin a couple days prior. Both parents reported they were out of money and had no drugs left; however, CV's father did have paraphernalia. Both parents agreed to drug screens at the local [REDACTED] and both tested positive for heroin.

CV's mother reported she swaddled CV, laid her down for a nap on her back in the middle of the family bed and went to the local mini market before they started to watch movies. CV's father

reported mother swaddled CV and gave CV to him while she ran to the local mini market. CV's father reported he laid CV down for her nap on her back in the middle of the family bed. It should be noted the car of CV's mother was impounded that day at local mini market, confirming CV's mother did visit the store.

CV's parents reported to police CV does not sleep in bed with them, CV only naps in the family bed during the day. There was not a crib in the home for CV but a "makeshift bed" on the floor next to the parents' bed. Parents report CV typically sleeps on the "makeshift bed" of blankets and pillows in the evening. There was a pack 'n play in a separate bedroom where CV's sibling, age 16 months, reportedly slept.

██████████ attempted an unannounced home visit 5/23/14 but the visit was unsuccessful.

Casework Supervisor, ██████████, had a discussion with the deputy coroner on 5/27/14. "Heavy lungs" was described as being excessive air in CV's lungs. The coroner ruled out sudden infant death syndrome (SIDS) for CV but felt cause of death was some sort of suffocation. The only visible injuries to CV were a small scratch to her forehead and to her inner right calf. These injuries were not reported to be suspicious. Dirty diapers and drug paraphernalia were found in CV's home and the coroner expressed concern for ██████████. The coroner also expressed concern for CV being swaddled at 4 months of age and questioned whether a swaddled 4 month old could actually roll over as CV's mother alleges. The coroner reported he was waiting on an expanded drug panel taken on CV due to drug paraphernalia being found in home.

On 6/3/14 ██████████ interviewed CV's mother in the agency office. CV's mother reported she swaddled CV and gave CV to CV's father while she went to local mini market for soda and milk. Mother reported CV's father intended to lay CV down for a nap while she went to the store. Mother reported she fed lunch to CV's sibling when she returned from store then put CV's sibling down for nap in her pack 'n play. Mother reported she checked on CV after she lay sibling down and saw CV lying swaddled, on her back, in middle of family bed with her pink "binky" in her mouth. Mother reported she and CV's father finished watching the movie "Feels Good" and also started to watch another movie when the paternal uncle came into the home. Mother reported she went into parent's bedroom to get CV's father a t-shirt as he was going to leave the home with his brother. Mother reported she noticed CV face down on family bed when she went into the bedroom. Mother reported she picked CV up and noticed CV wasn't breathing. Mother reported she started to scream. Mother reported CV's father and paternal uncle came into the bedroom and they went for help. Mother reported CV recently began to roll and she reported she propped pillows on the bed to prevent CV from rolling off. Mother reported she and CV's father both attempted CPR but CV was blue and not breathing. Mother reported CV was swaddled as this was common practice and mother denied baby monitors in the home. CV's mother reported CV typically sleeps in a bassinet in parents' bedroom, 6 hours straight per night; however CV was not sleeping regularly the past few days. CV's mother reported she created a "makeshift bed" of pillows and blankets on the parent's bedroom floor for CV to sleep. Mother admitted to using heroin one week prior to incident and reported she hopes to move to ██████████

Pathologist and Deputy Medical Director, [REDACTED], was available by phone and further explained the autopsy and pathology results. The team appeared to work as a cohesive group and openly shared information with each other as well as with the review team. The team noted the immediate response by the police department to be a strength. The team also felt that the pending police investigation was a strength in that they are conducting a thorough investigation before making a determination.

- Deficiencies: No deficiencies were found on the part of CYS. The family was not known to the agency at the time of CV's death. A question was raised whether mother should have received a [REDACTED] [REDACTED]. The Schuylkill County District Attorney's office was invited to the team review but did not attend. This was identified as a weakness.
- Recommendations for Change at the Local Level: A lengthy discussion was held regarding the safe sleep information provided to parents following birth of a child and the excessive amount of information a new parent is expected to absorb. Community resources were identified for sharing and reiterating safe sleep arrangement information including pediatricians and Nurse Family Partnership. CPS Supervisor also indicated a Multi-Disciplinary Investigation Team (MDIT) symposium is planned within the next year and safe sleep is a topic for discussion.

A question was raised whether mother should have received a [REDACTED] consult prior to CV's [REDACTED] due to poor prenatal care. The agency plans to discuss at their MDIT symposium that referrals do not need to be made only in abuse situations, but can be made if the family needs assistance or lacks parenting skills etc.

- Recommendations for Change at the State Level: There were no recommendations noted at the state level.

Department Review of County Internal Report:

The county provided a written report regarding the Act 33 meeting on 9/12/14. The county [REDACTED] related to this case. NERO questioned why the county [REDACTED] when criminal action was still pending. The police want to conduct a polygraph test with the father to ensure that he was being honest regarding his rendition of the day's events. NERO believes that the case could have remained [REDACTED] until the police completed their investigation. On 9/15/14, there was a discussion with the CPS Supervisor regarding this. The supervisor felt that there was no evidence that the drug use impaired the parents' decision to place the baby in their bed. They felt that while it may have been a poor choice, it was accidental in nature. The county reported that if this had occurred after 12/31/14, [REDACTED] based on the parents' reckless behavior, however they felt that the law does not currently allow for this.

Department of Human Services Findings:

- County Strengths: The county continues to have a strong Act 33 team and the team conducts a thorough critical analysis of each case presented. Schuylkill County CYC has good relationships with the police in the community and their investigations are usually collaboration between CYC and the police. Information is shared between the agencies.
- County Weaknesses: NERO did believe that the determination for the [REDACTED] could have been a [REDACTED] until the police finished their investigation.
- Statutory and Regulatory Areas of Non-Compliance: There were no statutory violations regarding this case. All paperwork was completed as per regulatory requirements.

Department of Public Welfare Recommendations:

The NERO agrees with the recommendation for the MDIT symposium in the county. Because this child was not known to the agency, it does not appear that they could have done anything differently. It is uncertain if the child was subject to a drug screen at birth, which could have triggered a report as required by law. Information about the mother's drug history and concerns with limited prenatal care should trigger testing as well as, at a minimum, a social work assessment while in the hospital. The Department recommends standard guidelines be issued to all hospitals in the Commonwealth regarding testing of newborns.

As mentioned, NERO believes that a [REDACTED] would have been appropriate, but the agency felt that the death was accidental in nature and was not related to drug use.