



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

## **REPORT ON THE FATALITY OF:**

**Bronx Kulha**

**Date of Birth: 12/21/2013**  
**Date of Death: 02/05/2014**  
**Date of Oral Report: 02/05/14**

### **FAMILY KNOWN TO:**

**Schuylkill County Children and Youth Services**

### **REPORT FINALIZED ON:**

**06/10/2015**

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. Schuylkill 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>
Bronx Kulha	Child Victim (CV)	12/21/2013
[REDACTED]	Sibling	[REDACTED] 2012
[REDACTED]	Sibling	[REDACTED] 2011
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Mother	[REDACTED] 1990
[REDACTED]	Father	[REDACTED] 1992

**Notification of Child Near Fatality:**

On 02/05/2014 [REDACTED] contacted Schuylkill County Children and Youth to report EMS and police responded to a "911" call at 2:30 AM regarding Bronx Kulha being unresponsive in his home. CPR was attempted at the home but was unsuccessful. Bronx was transported to St. Luke's Memorial Hospital [REDACTED] where he was pronounced dead. [REDACTED] reported he was not [REDACTED] but stated [REDACTED] reportedly saw no obvious signs of injury or trauma to Bronx. It was further stated in the referral that the parents are known for concerns relating to drug and alcohol use and domestic violence. [REDACTED]; however, could not rule out SIDS or shaken baby syndrome at this time.

**Summary of DPW Child Near Fatality Review Activities:**

The NERO received a copy of the agency record and conducted a thorough file review. On 02/26/2014, the County conducted an Act 33 meeting regarding this case. NERO participated in this review via telephone. There were discussions regarding the [REDACTED]

**Children and Youth Involvement prior to Incident:**

On 06/19/2011 the agency received a referral from the [REDACTED] Police regarding a domestic violence incident between mother and father the prior evening. The parents did not reside together. The mother resided with her mother and the father resided with his mother. The mother frequented the father's home, however, and took [REDACTED] (older sibling of Bronx) [REDACTED]. During the investigation there was documentation that the 2 year old (older sibling of Bronx) did not have his own bed at either parent's home. The mother and father shared a bed with the 2 year old (older sibling of Bronx) and stated they had done so since his birth. The parents were advised of the safety concerns regarding co-sleeping.

During the investigation, a second domestic violence incident occurred on 07/04/2011 when the father assaulted the mother while she was holding the 2 year old (older sibling of Bronx), resulting in a scratch to the child. The father was reportedly high on bath salts during this incident. The father was incarcerated following the incident 07/04/2011 but released the following week on bail. Following the father's release from prison, the mother resumed contact with him. The mother did not appear to recognize the safety concerns for [REDACTED] (older sibling of Bronx) and as a result on 08/31/2011 the agency implemented a safety plan. The safety plan stated [REDACTED] (older sibling of Bronx) would remain in the care of his maternal grandmother and her paramour until it was safe and appropriate for him to return to his parent's care. The maternal grandmother and paramour and/or another approved party by CYS were to supervise all contact between [REDACTED] (older sibling of Bronx) and his parents. Should the mother attempt to remove [REDACTED] (older sibling of Bronx) from the home of his maternal grandmother without appropriate supervision, maternal grandmother or paramour will notify CYS. Supervised contact between [REDACTED] (older sibling of Bronx) and his father was to occur at a location other than maternal grandmother's home.

On 09/26/2011 [REDACTED] (older sibling of Bronx) [REDACTED] remained in his mother's care. All contact between [REDACTED] (older sibling of Bronx) and his father [REDACTED] supervised by the paternal grandmother or another adult approved by CYS. The mother was not permitted to supervise contact between [REDACTED] (older sibling of Bronx) and his father. The father admitted to illegal drug use during this intake assessment and [REDACTED]. The family was open for General Protective Services and a referral was also made to the [REDACTED] to work with the parents in understanding positive and safe interactions.

In December 2011 the father [REDACTED]

[REDACTED] The mother and father were beginning to frequent each other's homes with the children, working on co-parenting. Maternal grandmother and paternal grandmother were assuring supervised contact of the father with the children [REDACTED]

[REDACTED]

[REDACTED] The mother continued to reside in her mother's home with the older siblings of Bronx while the father continued to reside in his mother's home.

**Circumstances of Child Near Fatality and Related Case Activity:**

On 02/05/2014 the County was notified of the fatality by the [REDACTED] police. An on-call caseworker responded and met with the mother, the father, and Bronx's 3 siblings at 11:55 AM on 02/05/2014 at their home. It was learned the family had just moved into the home 3-4 weeks prior. The worker discussed the prior evening events with the parents. The parents reported Bronx generally feeds every 3 -4 hours. The mother stated she fed him around 7:00 - 8:00 PM and placed him in his Pac 'n Play. She said he woke again around 8:30 - 9:00 PM and she held him and put him back in the Pan 'n Play. The mother said she woke around 2:30 AM when the father was going to the bathroom and she noticed Bronx had been asleep for a while. The mother stated she checked on him in the Pac 'n Play and noticed he wasn't breathing. The mother yelled for the father to call "911." Photos were taken of the Pac 'n Play which documented a large pillow and a few blankets in the Pac 'n Play. There were no beds for any of the other children, just one double mattress set up in the parent's bedroom.

[REDACTED] Domestic violence was discussed with the parents and they denied any recent incidents. The father admitted to recently being discharged from prison on 01/28/14. He reported that he was incarcerated in May 2013 for parole violations. The parents reported they would be returning to the paternal grandmother's home to reside following Bronx's death as the father is supposed to reside with his mother as part of his parole stipulations.

On 02/06/14 the assigned [REDACTED] at the agency contacted the Adult Probation officer for the father, to inform her of the death of Bronx Kulha and inquire of the father's current stipulations.

On 02/07/2014 the worker made contact with the family at the paternal grandmother's home. A discussion was again held regarding the hours prior to Bronx's death and the parents maintained their story regarding his sleeping in his Pac 'n Play. Sleeping arrangements were assessed at the paternal grandmother's home and it was discovered that one sibling was sleeping in bed with his parents while the other 2 siblings shared a bed in the same bedroom as their parents. Smoke detectors were not located in the home. The worker addressed safety issues surrounding co-sleeping and instructed the family to secure smoke detectors.

The caseworker also interviewed collateral contacts who were believed to have information related to the family. The party interviewed reported [REDACTED] at 9:30 PM on 02/04/2014 and heard kids banging, and crying coming from the parents' home. [REDACTED] stated [REDACTED] went to the [REDACTED]

██████████ did not want to get involved, but stated ██████████ the crying had been going on for over two hours. ██████████ stated she had ██████████ knock on the door of the family home but no one answered. Following the knock, however, a male voice was heard inside the home so it appeared that the children were not home alone. Police were contacted with concerns and sent an officer to her home. Reportedly the officer arrived around 11:00 PM but did not knock on the door of the family home as the crying had stopped.

Additional collateral contacts were made with the Coroner's office where it was learned that the mother's demeanor at the hospital 2/5/14 described as a flat affect following Bronx's death and conflicting stories as to where Bronx was sleeping were concerning. No obvious signs of trauma were noted but further investigation into sleeping arrangements was suggested. Contact with Adult Probation, with concerns regarding heroin use by the father following Bronx's death.

On 02/12/2014 the caseworker visited the family home and drug tested both parents. The father tested negative and mother tested positive for heroin. It was noted that when worker was at the home, the family had secured smoke detectors and a Pac 'n Play.

Funeral arrangements were held for Bronx 02/14/2014. ██████████

██████████ the mother refused to complete a drug screen requested by the caseworker as the mother admitted to using heroin a few days prior when the children were left in the care of the paternal grandmother. ██████████

On 03/05/2014 the mother and father met with the caseworker and police at the ██████████ Police Station where it was disclosed all children had been sleeping in bed with the parents. A diagram was drawn showing where each individual (6 people total) were sleeping the evening of the death. The mother reported she woke up and found the 2 year old sibling's head on Bronx's chest; Bronx was unresponsive.

Subsequent home visits were held by the caseworker with the family 03/06/2014, 03/14/2014, 03/20/2014 and 03/26/2014. ██████████

██████████ Concerns were noticed regarding what was described as inappropriate/lackadaisical consequences for the children's negative behaviors. Discussions were held regarding routine bed time, feeding, etc. and it was learned the parents had no schedule for the children. ██████████

On 03/18/2014 ██████████

**Current Case Status:**

Criminal charges were filed on 04/02/2014 against the mother and father; 4 counts of endangering the welfare of a child and 4 counts of recklessly endangering another person. A preliminary hearing is scheduled for 05/06/2014.

[REDACTED] At this time, the family continues to reside with the paternal grandmother.

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

- **Strengths:** [REDACTED] provided the team with a verbal summary [REDACTED] [REDACTED] Police Department allowed for the "911" tape to be heard, informed the team of his interviews with neighbors and proposed interviews with parents. Adult Probation informed the team of the father's current bail stipulations and probation recommendations. Team members identified the family's cooperation with agency services and honesty regarding drug use as strength. [REDACTED] [REDACTED] was identified as a strength. Cooperation between the police and CYS was also viewed as strength.

**Deficiencies:** A discussion was held regarding factors that constitute a safety threat [REDACTED] [REDACTED] A discussion was held regarding the criteria utilized to assess how a parent's drug use affects their parenting ability/capability. The agency reiterated to the team that drug screens for the parents were negative on the date of Bronx's death and the father [REDACTED] following his son's death. It should be noted that there were no referrals on the family since the case had been closed in August of 2012. The agency was unaware of the 2 youngest children who were born after the case was closed.

**Recommendations for Change at the Local Level:** A discussion was held regarding the need for "drug drop off boxes" in Schuylkill County so that people have a place to drop off old, unused medications. Additionally, the need for local obstetricians/gynecologists to be educated on prevention resources for mothers who abuse drugs during pregnancy was discussed. The team identified illegal drug use as a reoccurring factor in homes with recent death of children. [REDACTED]

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

**Department Review of County Internal Report:**

The County report was received on 04/25/2014. The report was reviewed by the NERO and the state response to the County's unredacted written report was sent to the county on 05/02/2014. The NERO concurs with the report provided by the County. As previously mentioned, the NERO did discuss the case [REDACTED]

**Department of Public Welfare Findings:**

- County Strengths: The County has an Act 33 team that is invested in the process. The team will ask critical questions and is always looking at improving the services in the county to better ensure the safety of the children that reside there. The county appears to have a solid plan to work with the family moving forward, and is invested in keeping the family in the least restrictive environment.
- County Weaknesses: No county weaknesses were identified as a result of this analysis.
- Statutory and Regulatory Areas of Non-Compliance: There were no regulatory issues found related to this case. The family was unaware of the 2 youngest children in the family because no referrals were made to the county after the case was closed in August of 2012.

**Department of Public Welfare Recommendations:**

The Act 33 team identified areas of weakness in County service areas outside of Schuylkill County Children and Youth Services (see Recommendations for change at the local level). Members of the Act 33 team should reconvene to see which team members would be best able to affect change to the current practice. It should be noted that in past Act 33 meetings, areas were identified and team members conducted trainings and provided information to the community in an effort to eradicate any weaknesses they identified which may have contributed to a fatality/ near fatality in the county.