pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

CAMRON MICHAEL

Date of Birth: 6/12/12
Date of Death: 4/14/15
Date of Report to ChildLine: 4/07/15
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILD WELFARE AT THE TIME OF THE INCIDENT:

BERKS COUNTY CHILDREN AND YOUTH AGENCY

REPORT FINALIZED ON:
11/9/15

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. Section 6349 (b))

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Berks County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 4/28/15.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Camron Michael	Victim Child (VC)	6/12/12
[redacted]	Foster Mother	[redacted]1986
	Foster Father	[redacted]1986
	Sibling	[redacted]14
	Foster Brother	[redacted]11
	Foster Sister	[redacted]2003
	Foster Sister	[redacted]2005

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [redacted] Family from Berks County Children and Youth and [redacted] Private Provider Agency. Follow up interviews were conducted with the county intake caseworker and supervisor and the provider agency case worker and director on 4/15/15. The regional office also participated in the County Fatality Review Team meeting on 4/28/15 where sources of information were shared amongst the multidisciplinary team.

Children and Youth Involvement Prior to Incident:

There were previous reports of neglect and physical abuse while the VC's family resided in Northumberland County and the family received services in Northumberland County from 8/2013 to 12/2014. Concerns were drug use by mom, inappropriate parenting by both parents and [redacted] with both parents. The two older siblings were placed with the maternal grandmother in Snyder County. Dad, VC and his younger sister moved to [redacted] when mom was incarcerated for a violation of probation.

There was no Berks County Children and Youth agency involvement prior to the children being placed in the [redacted] home on 1/27/2015. Berks County Children and Youth Services became involved with the family on 1/26/15 when there were allegations of inappropriate housing. An unannounced visit revealed that VC and his then 6 month old sister were sleeping on blankets on a basement floor and VC's sister was being fed evaporated milk and had a rash on her neck and severe diaper rash. There was also a car seat growing mold. It was also alleged that dad was abusing illicit drugs, more specifically K2 or synthetic marijuana.

Circumstances of Child Fatality and Related Case Activity:

As a result of the county investigation, the family was accepted for service on 1/27/15 and the VC and his younger sibling were placed with the [redacted] family to receive foster care services.

On 4/7/15 the VC was taken to the Reading Trauma Center by EMS as a result of a report by the foster mother that the VC fell down a flight of stairs. The EMS reported that when they arrived at the foster home the VC was unresponsive. When the VC arrived at the hospital he was in critical condition. [redacted] Dr. [redacted], the doctor treating the VC at the emergency room, noticed that the VC had old bruises about the body and determined that the VC's injuries were suspicious of abuse. The case was certified as a Near Fatality. The VC was then transported to Hershey Medical Center (HMC) by medi vac from Reading Trauma Center. [redacted] was the treating doctor at HMC.

[redacted] indicated that the VC suffered from a horrible brain injury with swelling of the brain. [redacted] Initially the VC's injuries were described as life threatening and eventually the VC succumbed to his injuries on 4/14/15 [redacted] said that the VC was basically brain dead when he arrived at HMC and speculated that the VC's head was probably rotated. [redacted] indicated children do not die from tumbling down stairs and that the bruises on the VC's body were not synonymous with accidental injury.

Some of the injuries the VC suffered were identified as the following: [redacted] bruising to [redacted] the head and right ear, bruising to the lower back area [redacted].

There were concerns for the VC's safety expressed by his mother and maternal grandmother related to injuries that were observed and reported to the county prior to the incident on 4/7/15:

- On 3/6/15 the bio mother called and left a voice message to the county caseworker reporting that she observed bruises on the VC during a visit. The county caseworker indicated that she attempted to return the call but was unsuccessful in reaching the bio mother.
- On the 3/9/15 [redacted] sent an email to the county caseworker reporting that the VC was losing weight and had bruises and scratches and that he had fallen down the stairs at the foster home.
- On 3/13/15 the Berks Caseworker and [redacted] caseworker visited the foster home and noted injury to the VC sibling's eye and scratches to the VC ankles. The foster mother explained that the injury to the sibling's eye was caused by VC tossing a toy at his sister and the scratches on the VC ankle were the result of the VC attempting to pull his ankle high socks higher up his feet.
- The was a call from the VC's maternal grandmother to the county caseworker on 3/16/15 regarding concerns for the children's care in the foster home.

The incident occurred on 4/7/15 and the [redacted] report was made on the same day to Berks County Children and Youth. All relevant parties were interviewed and the home was assessed for the safety of the VC, his younger sibling and the other children in the home. The children were also medically assessed and there were no concerns. The maternal grandmother has been included in the safety plan. The sibling, [redacted] resided with the maternal grandmother for one month and was then place in a kinship home.

The [redacted] determination was [redacted] with the [redacted] named as perpetrators. The safety plan for the VC's sibling included the maternal grandmother but the child remained with her for one month and was placed in a kinship home on 5/2/15. The investigation is still open and law enforcement is awaiting the Medical Examiner's report.

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

There was collaboration between the county and the multidisciplinary team during the investigation. There were deficiencies from the county in compliance with regulations and statutes regarding children and families. As a result, licensing and inspection summaries were issued to Berks County and [redacted]

Department Review of County Internal Report:

The South East Regional Office of Children, Youth and Families received the county review team report on 6/11/15 and agreed with the report and its findings.

Department of Human Services Findings:

- County Strengths:

The county worked collaboratively with the police and the multidisciplinary team members and ensured the safety of [redacted] and the other children in the foster home.

[redacted]

- County Weaknesses:

Weaknesses were noted with the issuance of the Licensing and Inspection Summary which addressed areas of non-compliance.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency

There were areas of non-compliance and LISs were issued to the county agency and the private provider. The areas of non-compliance noted for the county agency include the following:

3490.08.01 The County Agency failed to ensure that a Developmental Evaluation was performed for the VC and failed to follow the [redacted] Referral Policy.

3130.11 The County Agency failed to ensure that a child in its custody was protected from abuse.

3130.31 (2)(ii)(A)(B)(iii) The County Agency failed to report incidents of abuse of a child in their custody and failed to ensure that medical care was provided to a child within the required time frames, after coming into care.

Department of Human Services Recommendations:

Berks County Children and Youth needs to review the current monitoring procedures that the agency has in place, and make the necessary changes to be proactive, to ensure that kids' safety, permanency and well-being needs are met while in placement.