REPORT ON THE FATALITY OF

Anthony C. Czarnecki Jr.

Date of Birth: 03/02/2017
Date of Death: 05/27/2017
Date of Report to Child Line: 05/26/2017
CWIS Referral ID: [redacted]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Berks County Children and Youth Services

REPORT FINALIZED ON:
01/11/2018

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))

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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 convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/06/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Anthony Czarnecki Jr	Victim Child	03/02/2017
	Mother	1990
	Father	1982
	Paternal Grandmother	1947

Summary of OCYF Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current investigation notes and gathered information from Berks County Act 33 teaming. Follow up interviews were conducted with Berks County's Administrator and Social worker. Hospital records were reviewed.

Summary of circumstances prior to Incident:

On August 2012 a referral was accepted for investigation involving mother's other two children. In October 2012, the case was passed to the in-home department and the service providers In September 2013, the case was passed to the placement department. The service providers In August 2014 the case was passed to In April 2017, and the in-home department handles the new referral involving the victim child. Services were Victim child was born premature at Reading Hospital & Medical Center (RHMC) on 03/02/2017 at 31 weeks and two days. Child tested positive for at birth and was experiencing withdrawal symptoms Mother has a history of heroin use and has been clean for one year. Mother has had previous involvement with BCCYS.

Father also has a drug history, however, he has been clean for several years and is a strong support to mother in her sobriety. Mother has been utilizing services through BCCYS Family Group Decision Making (conference held 04/17/2017), so that she could care for Anthony Mother was successful and Anthony to mother and father's care on 04/10/2017.

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

On 05/26/2017, BCCYS received a near fatality report stating that the victim child was brought to RHMC emergency department unresponsive. Parents reported that he fell off of the couch on 05/24/2017. Mother fell asleep on the couch with him in her arms. She stated that she woke when she felt movement to find that he had fallen off of the couch face first. The only injury noted by the parents at this time was a small mark above his eye characteristic of a brush burn. Parents monitored him throughout the day and reported he ate normally for the remainder of the day and they didn't see any no further concerns.

Parents reported on 05/25/2017 that there was bruising developing on both of his eyes. He was still acting and eating normally. However, by the morning of 05/26/2017, the bruising had spread all over his face and his face began to swell. Parents planned to take him to the hospital when father was done working that evening. He presented normally until approximately 3:00 PM when mother noticed that he was running a fever. Mother gave him Pedialite of which he only drank a small amount.

When father returned home from work around 6:00 PM, father put him in his car seat and noted that child began to look downward. He appeared as though he was seizing then an orange substance came out of his mouth and he lost consciousness. Father called 911 and mother started to administer CPR. EMS arrived and he gained consciousness again.

While at RHMC, Dr. certified the victim child to be in serious critical condition. RHMC planned for Anthony to be transferred to Hershey Medical Center as soon as possible. However, on 05/27/2017 at 12:34 am, the victim child was pronounced dead at Reading Hospital.

BCCYS CW also conducted interviews with the parents on 05/27/2017. Police Department also responded to the hospital and interviewed both parents. An autopsy was performed on 05/29/2017. The results were inconclusive. There was no obvious trauma noted and no physical injuries aside from the bruising to his eyes. He sustained rib fractures which are understood to be a result of administering CPR. determined that the

brain abnormalities that were noted in the original scans were actually masses indicative of cancer. Several of these masses were found on Anthony's skull and liver. [redacted] could not determine with certainty that the bruising to his face/eyes was a result of falling, as this could have been from an underlying medical condition. [redacted] will not be able to determine a cause of death until after his brain is examined further. The Autopsy revealed that the cause of death was acute aspiration Pneumonia and Probably sepsis and Acute Moncytic Leukemia. The manner of death was determined to be natural and the case was [redacted]

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

- Strengths in compliance with statutes, regulations and services to children and families; including cooperation between law enforcement and County agencies during investigation of suspected Child abuse investigations; Safety Plan was initiated promptly, Collaboration between BCCYS, Reading Hospital and Hershey Medical Center. Collaboration between BCCYS law enforcement in the investigation. Case was open with BCCYS prior to this incident due to mother's heroin [redacted] Family was linked to appropriate [redacted] services.

- Deficiencies in compliance with statutes, regulations and services to children and families; No deficiencies were noted. Concerns identified during case review were the mother's substance abuse history [redacted] and the history of the two siblings previously being removed from her care. [redacted] However; it was determined that the family was receiving comprehensive services and the mother was compliant with all recommendations from BCCYS [redacted] Primary Care Physician voiced concern that their office was not contacted for medical information on the Child when he received care/deceased at Reading Hospital. Reading Hospital has documentation of call being placed to the Practice. Discussions were revolving around the need to alert the primary care Providers if a case of child abuse or neglect presents in the Emergency Room of any of the area Hospitals.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse; No recommendations. There were multiple discussions revolving around what would be the appropriate level of Supervision and follow up for families [redacted]

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; None Identified.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse. No

recommendations. There were multiple discussions revolving around what would be the appropriate level of Supervision and follow up for families

Department Review of County Internal Report:

The Southeast Region Office received the Berks County Fatality Team Report on 08/31/2017 and is in agreement with the report.

Department of Human Services Findings:

- County Strengths: included cooperation between law enforcement and County agencies during investigation of suspected Child abuse investigations; Safety Plan was initiated promptly, Collaboration between BCCYS, Reading Hospital and Hershey Medical Center. Collaboration between BCCYS law enforcement in the investigation.

- County Weaknesses: There were discussions revolving around the need to alert the primary care Providers if a case of child abuse or neglect presents in the Emergency Room of any of the area Hospitals.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. None Identified

Department of Human Services Recommendations:
There should be more education around mental health and substance abuse issues.