pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Mya Lopez

Date of Birth: 04/24/2017
Date of Death: 06/20/2017
Date of Report to ChildLine: 06/21/2017
CWIS Referral ID: [redacted]

FAMILY NOT 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:
01/16/2018

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))

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 Children and Youth Services has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 08/01/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
Mya Lopez	Victim Child	04/24/2017
[redacted]	Biological Mother	[redacted]1982
*[redacted]	Biological Father	[redacted]1984
[redacted]	Sibling Maternal Half	[redacted]2003
*[redacted]	Sibling Maternal Half	[redacted]2004

[redacted] lives with his biological father in Florida.

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Fatality Review Activities:
The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current records pertaining to the [redacted] family. SERO staff reviewed various reports, assessments and case documentation provided by the Berks County Children and Youth.

Children and Youth Involvement prior to Incident:
On 01/19/2006, the family became known to Berks County Children and Youth Services regarding the child [redacted] The report was a [redacted] The report was determined [redacted] There were no services planned or provided.

On 02/04/2011, Berks County Children and Youth Services received a report regarding child [redacted] The report was a [redacted] The report was screened out, the referral did not allege child abuse or neglect.

Circumstances of Child Fatality and Related Case Activity:

On 6/20/2017, Berks County Children and Youth Services received a [redacted] report regarding the fatality of the victim child. A police officer that was in the neighborhood was flagged down by a neighbor to attend to the victim child. The officer entered into the home and found that the victim child was receiving CPR. The 14-year-old female sibling of the victim child was babysitting the child while mother was at work. This was a frequent responsibility for the 14 year old as mother was sick after the victim child was born, therefore the 14-year-old sibling helped mother since the child's birth.

The 14-year-old sibling noticed the child had discoloration and had stopped breathing. The sibling attempted CPR and did not get a breathing response from the child and she then ran outside to a neighbor's home. A neighbor went into the home of the child and also attempted CPR. A neighbor called 911; the police were in the vicinity and was also flagged down to assist. The EMS (Emergency Medical Services) arrived at the home at the same time the police officer arrived. The police and EMTs found the child deceased. The child was transported to Reading Hospital via ambulance.

The sibling did not have any way to make contact with their mother and she did not have a cell phone. The child's phone was taken away from her by the mother as a form of punishment. The mother could not be reached until later that evening.

The mother was not home at the time of the fatality. It was determined that she went to the store in the morning and informed sibling that she would be right back. However mother did not come right back and when she returned she did not check in on the victim child. Mother did go to work as well as spending a portion of the day with the subject child's biological father. Mother reported that she felt comfortable leaving the victim child with the 14-year-old sibling. The biological father does not live in the home and reported that he had not seen the child in a month.

The investigation determined that the 14 year old sibling woke up that morning around 8:00am to feed the baby and she put the baby back in the bassinet. The mother left the home around 8:30am. The 14 year old went back to sleep and she slept all day. The mother came home around 3:40 pm and asked if the baby was alright. Mother did not check on the baby. Mother then left the home again around 4:10 pm. The 14-year-old sibling woke up at 4:30 pm and she noticed the child was purple and not breathing. At this time she performed CPR on the victim child. As the child did not respond to the CPR the 14 year old ran outside to neighbors. A neighbor came into the home and performed CPR while another neighbor called 911 and then saw a police car and flagged the officer down to assist.

On 6/21/2017, the report was re-evaluated and determined to be a [redacted]

On 08/17/2017, the initial status determination of the investigation was [redacted] based on law enforcement investigation.

On 10/20/2017, the report was determined [redacted] on [redacted] It was determined that the victim child had not been attended to between 8:30 am to 4:30 pm. The child died due to being face down in the bassinet with soft bedding.

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

Strengths in compliance with statutes, regulations and services to children and families:

- There were none identified.

Deficiencies in compliance with statutes, regulations and services to children and families:

- There were none identified

Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse:

- There were none identified.

Recommendations for changes at the state and local levels on monitoring and inspection of county agencies:

- There were none identified.

Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse:

- There were none identified.

Department Review of County Internal Report:
The Department received the County report on 08/27/2017.

Department of Human Services Findings:

County Strengths:

- The County completed an extensive investigation. The County worked effectively with the law enforcement regarding the investigation.

County Weaknesses:

- There were none identified

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

- There were none identified

Department of Human Services Recommendations:

The Department recommends intensive infant care training centered on development, age appropriate supervision for infants and young children. This should be provided by neo natal hospital staff and the pediatric community.