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REPORT ON THE FATALITY OF

Kayla Marie Taschler

BORN: 02/17/09

DATE OF FATALITY: 01/20/2010

**FAMILY WAS NOT KNOWN TO
CARBON COUNTY CHILDREN AND YOUTH SERVICES**

DATE 06/02/2010

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality review and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Father	[REDACTED]/76
[REDACTED]	Mother	[REDACTED]/82
Kayla Taschler	Victim	02/17/09
[REDACTED]	Sibling	[REDACTED]/05
[REDACTED]	Sibling	[REDACTED]/06

Notification of Fatality:

The mother reported she put the Victim Child (VC) to bed on 01/19/10 at approximately 8:00 P.M. The parents did not have a crib; they utilized a car seat which did not have a stable base. Neither parent checked on the child until the following day (01/20/10) at noon. At that time the mother found the child unresponsive. The mother telephoned her husband and several relatives for assistance in transporting the VC to Palmerton Hospital. The mother further reported that she bathed and changed the child prior to transportation being arranged. The police discovered urine soaked clothing and urine soaked car seat in the child's bedroom. There was drug paraphernalia, deplorable housing conditions, and little food. As a result, the Carbon County Children and Youth Services Agency was notified.

Documents Reviewed and Individuals Interviewed:

Both the mother and father were interviewed by the Lehigh State Police. Carbon County Children and Youth Services were provided copies of these statements. Upon being summoned to the family residence by the police the agency caseworker assessed the home and confirmed the findings of the police. The caseworker proceeded to locate the VC's siblings at the home of the paternal grandparents. The caseworker proceeded to their home and briefly interviewed all parties present. However, the parents were at the police station at the time and were not interviewed. That day the police interviewed the parents without the knowledge of the caseworker. The caseworker attempted to interview the parents at a later date, however they were advised not to participate in the interview by their legal counsel. It should be noted that the agency was not able to obtain a copy of the autopsy for their review. The District Attorney allowed the agency to review the document, but not copy it. NERO reviewed the files including interviews and medical reports.

Case Chronology:

01/20/10 Carbon County Caseworker (CW) received a referral from [REDACTED] reporting a suspicious death and deplorable home conditions. [REDACTED] further reported a young unresponsive child was transported to the local hospital and was presumed dead. [REDACTED] were also concerned for the two other children residing in the home because of the deplorable conditions.

The caseworker reported to the scene of the abuse. At the scene there were several police officers. The VC's paternal grandparents had already arrived and taken the VC's siblings to their home. The agency spoke to the grandparents who indicated she had recently taken care of the VC and had no concerns.

01/21/2010 The agency CW called the VC's primary care physician [REDACTED]

[REDACTED] (It should be noted that the

VC's weight at the time of death was 12.5 lbs.)

01/22/2010 Autopsy held

02/19/2010 [REDACTED]

3/12/2010 The agency confirmed concerns (children wearing diapers, not being fed appropriately, etc.) that the CW had for the paternal grandparents and the VC's siblings were [REDACTED]

03/15/2010 [REDACTED]

03/16/2010 [REDACTED]

04/29/2010 County received results of autopsy from the District Attorney's office (the Coroner refused to release the results to the Carbon Children and Youth Agency.

04/30/2010 [REDACTED]

05/06/2010 [REDACTED]:

- [REDACTED] - Paternal Great Aunt and Uncle
- [REDACTED] - cousin
- [REDACTED] - Maternal Uncle and Aunt
- [REDACTED] - Paternal relative
- [REDACTED] - Maternal Grandmother
- [REDACTED] - Maternal Grandfather
- [REDACTED] - Paternal Grandparents
- [REDACTED] - Paternal Aunt and Uncle

05/18/2010 [REDACTED]

05/18/2010 Parents arrested, charges include Involuntary Homicide and Child Endangerment. Arraignment for the parents in front of Magistrate [REDACTED], Bail for [REDACTED] - \$150,000 straight, Bail for [REDACTED] - \$100,000 straight

05/26/2010 Preliminary Hearing in front of Magistrate [REDACTED]

05/28/2010 Magistrate [REDACTED] reduced bail to \$30,000 with 10% down. Bail posted by family same day.

06/01/10 Agency notified the [REDACTED] family that the agency would like to [REDACTED]
[REDACTED]

06/21/2010 [REDACTED]

Previous CY involvement:

The family was not known to the Carbon County Children and Youth Services.

Circumstances of Child's Fatality:

The VC was 11 months old and only 12.5 lbs at the time of death. The VC died of Cachexia and dehydration.

Current / most recent status of case:

- [REDACTED]
- Family resources are currently being assessed
- The surviving children continue to [REDACTED]
- Involuntary Manslaughter/Child Endangerment charges have been filed against both parents.

Services to children and families:

The family is open for [REDACTED] services. Both parents are incarcerated. [REDACTED] are being explored and [REDACTED] for the VC's siblings.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Fatality/Near Fatality Report:

There were no recommendations for change at the county level. However, it should be noted that the agency strongly criticized [REDACTED]

[REDACTED] As a result, the agency requested the District Attorney's Office consider charging [REDACTED]
[REDACTED]

Statutory and Regulatory Compliance issues:

- An immediate safety assessment was done regarding the VC's siblings. A safety plan was established. However, the children were ultimately [REDACTED] as a result of [REDACTED]
- The [REDACTED] was completed in a timely manner. All letters and CY104 were sent out in a timely manner.
- Risk assessment was completed and accurate.

Findings:

The family/children were not known to the agency. The agency's [REDACTED] was comprehensive. However, the supervisor reviews did not thoroughly document the ongoing developments of the case. It should be noted the agency conducted a thorough internal review and produced a well written summary of the meeting.

Recommendations:

NERO recommends the CCCYS increase the documentation regarding supervisory reviews.

NERO recommends the Carbon County Coroner's Office provide copies of autopsies regarding child fatalities/ [REDACTED] to CCCYS.