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REPORT ON THE FATALITY OF

Alyssa Heller

BORN: 4/12/10
DATE OF FATALITY: 6/25/10

FAMILY NOT KNOWN TO:
Schuylkill County Children and Youth

REPORT DATED 10/12/10

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 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 reviews 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>
Alyssa Heller	Victim	4/12/10
[REDACTED]	Sibling	2 years old
[REDACTED]	Mother	[REDACTED]/88
[REDACTED]	Father	[REDACTED]/87

Notification of Fatality:

On 6/25/10 the county received a [REDACTED] fatality report which was subsequently received by the Northeast Regional Office on the same day. The child was reportedly taken to the ER in full cardiac arrest. The mother reported that the child was laid to sleep between 10 PM and 11PM on 6/24/10. The mother checked on the child between 10 AM and 11 AM on 6/25/10. The EMS was not paged until 12:05 PM. The child had her blanket wrapped around her head and upper torso. The only thing the mother could see was the child's feet. The child was pronounced dead at 12:45 PM. The county is suspicious that the child died due to the mother's neglect.

The State police became involved immediately in this case. The family was not known to CYS prior to this incident. Schuylkill County CYS made an immediate response to the home. The parents were questioned by the police, and although their stories were consistent, there was a definite concern regarding the 2 month old not being checked on over a 12 hour period. There were also safety hazards in the home. There was a second story open window with no screen, uncovered electrical outlets, and rotting food in the 2 year old's room. The apartment was also extremely hot (84 degrees in the home on the evening of the visit). CYS deemed the surviving child unsafe to remain in the home at that time. He was sent to stay with his paternal grandparents who were present at the home at the time of the visit. This was agreed to and facilitated by the agency as the safety plan.

The preliminary report from the coroner showed petechia of the lungs. This could be associated with SIDS. The coroner reported at that time that further investigation would be needed to determine cause of death.

Documents Reviewed and Individuals Interviewed:

The parents were seen on 6/25/10 when the agency received the referral. The parents were interviewed by the police but refused to speak with children and youth on the advice of their attorney. [REDACTED] is 2 years old and non verbal. The agency was able to receive interview information (Where the parents were, when they found the child etc.) from the state police who interviewed the parents.

NERO read the agency file and attended the second death review on 7/13/10. NERO also spoke to the caseworker assigned to the case regarding her investigation and findings.

Case Chronology:

6-25-10-The child was found unresponsive and taken to the hospital. The child was pronounced dead at the hospital and a child fatality report was filed.

6/25/10- the agency made an immediate response to the home and a safety plan was created for the 2 year old sibling of the deceased child. The maternal grandmother and step-grandfather took the 2 year old to their home and agreed to supervise contact with the parents. The parents were also seen at this time, as mentioned above, but they refused to be interviewed on the advice of their attorney.

6/26/10-Autopsy performed.

6/28/10-Schuylkill County CYS made a home visit to the grandparents' home to ensure it was safe for the 2 year old. Police and Childline Checks done on grandparent's on this date.

07/01/10-CY-104 (referral to law enforcement as required by the Child Protective Services Law) sent to the police department.

7/13/10- Death review team convened.

7/14/10-A home visit was conducted on this date. [REDACTED]

08/09/10- [REDACTED]

08/11/10-The agency received the EMS report from the incident.

08/13/10- [REDACTED] filed by the county with an [REDACTED] on both parents.

08/27/10-Second death review team convened (NERO attended this meeting).

09/13/10- [REDACTED]

09/20/10- [REDACTED]

Previous Children and Youth Involvement:

There was no previous children and youth involvement in Schuylkill County. The family was originally from Berks County, so Berks County Children and Youth was contacted and there was no prior involvement in Berks County either.

Circumstances of the Child's Fatality:

The child was found by the mother unresponsive in the crib at approximately 10:00AM. The child had not been checked on for a period of 12 hours. The child was in full cardiac arrest when she arrived at the hospital. The parents refused from the onset to be interviewed by CYS, however, the parents' interviews with the police indicate that the mother went to bed shortly after she put the infant to bed and did not wake up until she was awoken by her husband calling her from his cell phone (the husband was reportedly calling her from downstairs in their home. The father reported that he works 3rd shift. He worked later than usual that day. He came home and showered, cut the grass, and went on the computer. He did not check on the infant. He did see the 2 year old and told him to go into his room and play. At some point while he was on the computer, he called his wife and woke her up. When she checked on the infant, she had a blanket over her face and she was not breathing. 911 was called within minutes (the police confirmed this to be true) although originally, there was a discrepancy in the time sequence. The child was pronounced dead at the hospital.

Current / Most Recent Status of Case

- The Agency [REDACTED] both parents as [REDACTED].
- The agency attempted to accept the case for service and attempted to obtain [REDACTED] 2 year old child, however, the agency [REDACTED]
[REDACTED]
- The agency [REDACTED] [REDACTED]. At this point, the parents refused services through CYS and the case was closed.
- The 2 year old is currently in [REDACTED].
- The family has refused services through CYS on the advice of their attorney. The agency felt they had no other recourse then to close the case.

Statutory and Regulatory Compliance

- There was a safety assessment conducted on the day of the referral at the parent's home, however the safety plan was for the child to go with the grandparents and no safety was done at the grandparents' home. Additionally, Childline and Criminal checks were not completed on the grandparents until the following Monday.
- The safety assessment on the grandparents' home was not completed in a timely manner. The child was with the grandparents for an entire weekend before the home was inspected or checks were run.

- The [REDACTED] was completed in less than 60 days.
- The agency conducted two death review meetings (7-13-10 and 8-27-10) regarding this case. The agency had the required representation from the community. The second meeting was held because the team did not feel that there was enough information after the first meeting. The results of the autopsy were not yet available and they felt that that was an important piece of information. The team felt there was good collaboration between the agency and the state police; however, the team was concerned that [REDACTED]. The team believed that based on the conditions of the home at the time of the child's death, as well as the lack of supervision of both children at the time of death, there was sufficient information to [REDACTED]. They did not have the parenting skills on their own to see what the hazards in the home were. The agency presented at this time their plan to [REDACTED]. Although it was brought up at the meeting that there was no new information to [REDACTED], the agency felt this was their only recourse. The team conducted a critical analysis of the case and found that the county's [REDACTED]. Training in this area was strongly recommended.
- The agency attempted to interview the parents however they refused on the advice of their attorney. The state police did provide information from their interview to CYS.
- The risk assessment was not done in a timely fashion. The death occurred on 6/25/10 and the risk assessment was not completed until 9/21/10. This should have been completed no later than 60 days after the investigation began. The county was issued a Licensing Inspection Summary citation regarding the risk assessment.
- The family refused services and [REDACTED], so the case was not opened for service.
- Although there is another child, the family refused services, so no referrals were made.
- The CY-104 (referral to law enforcement) was sent in a timely manner.

Findings:

It appears the State Police and the CYS Agency worked collaboratively on this case. There was a sharing of information and the state police attended the death reviews conducted by the county. There were concerns noted at the death review regarding the [REDACTED]. The agency acknowledges that the [REDACTED].

[REDACTED] NERO had advised the county to [REDACTED]. The [REDACTED] county [REDACTED].

NERO issued a Licensing Inspection Summary citation to the county based on the fact that they did not ensure that the grandparents' home was safe prior to sending the child there for the weekend and another Licensing Inspection Summary citation was issued for not completing the risk assessment in a timely manner in accordance with Chapter 3490 of the regulations.

Recommendations:

NERO has recommended that the county receive further training in court preparation. This was further discussed at a subsequent NGA meeting. NERO has also discussed with the county the need to do safety assessments prior to placing a child with a relative as well as the need to complete a risk assessment at the conclusion of an investigation, not to exceed 60 days. Citations were issued regarding these issues. It was recommended that training in court testimony and court preparation be accessed by the county for all casework and supervisory staff.