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REPORT ON THE FATALITY OF:

Tamera N. Adams

Date of Birth: August 25, 2010
Date of Fatality: October 16, 2011

**The family was not known to
any private or public social service agencies**

Date of Report: March 16, 2012

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 1147, Printer's Number 2159, was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child 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.

Family Constellation

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Tamera N. Adams	Victim Child	08/25/2010
[REDACTED]	Mother	[REDACTED] 1992
[REDACTED]	Father	[REDACTED] 1991
[REDACTED]	Maternal Grandfather	[REDACTED] 1968

Notification of Child (Near) Fatality

Mercer County Children and Youth Services (MCCY) received the information on the child death on October 16, 2011. It was reported to the agency by [REDACTED] of the Hempfield Police Department via information obtained from [REDACTED] that the victim child was brought into the ER on October 15, 2011 at 4:50 pm. The child was unresponsive and believed to have died as a result of [REDACTED]

Summary of DPW Child (Near) Fatality Review Activities

On October 27, 2011, the Western Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. This included the initial intake, contact summaries, interviews conducted by the county and the medical records of the deceased child. There was no known history with the family with MCCY except the information on mother's childhood history.

On October 17, 2011, coroner [REDACTED] conducted the autopsy on the deceased Tamera Adams. The autopsy report was completed by [REDACTED], from Erie, Pennsylvania upon review of the coroner's findings. The opinion that was given was that the circumstances and clinic-pathological elements in the death of Tamera Adams, a 13-month old female, were compatible with environmental hyperthermia.

The region received the [REDACTED] Investigation Report [REDACTED] from the county on December 14, 2011. Both parents were [REDACTED] because the county

believes that the child was left unsupervised for approximately 17 hours. The county also discovered that there was a Protection From Abuse Order (PFA) dated June 7, 2011 in effect that the mother filed against the father and the father was not to be around the victim child alone. However, the mother allowed this to occur.

Summary of Services to Family

There were no services provided to the family due to the agency not having contact with the family until after the death of the child. The agency did not accept the case for services due to the fact that there were no other children in the home.

Children and Youth Involvement Prior to Incident

There was no history with MCCY prior to this report with the [REDACTED] family. However on October 18, 2011, a call was received from Crawford County CYS. There was a report on the mother when she was a child and her last name was [REDACTED] Mercer County obtained this information by conducting a cross county search which revealed a prior case which occurred in Crawford County. There was an intake record in 2008 and the family received [REDACTED]. At the time, the mother was diagnosed with [REDACTED]. In 2001, the mother (as a child) had gone through some family problems. The family lost a lot of their belongings in a house fire and the parents were going through a divorce. They did not have any other information.

Circumstances of Child Fatality and Related Case Activity

[REDACTED] reported that they received a call that a 13-month old child was coming in that was unresponsive. The child came in wrapped in an EMS blanket. The child was postured, arms dorsiflexed, eyes dried and glazed and no signs of life. The child was wearing a short sleeve shirt and had a diaper on. She was not wearing pants. The pants were on the bed and life force may have taken them off. [REDACTED] came into the ER and there were no signs of life. The child had a rectal temperature of 104. The baby felt hot to the touch. The diaper was extremely soiled from the lower back up to the belly button. The child had a diaper rash. There were marks on the right wrist that may have been bruising. The child's lips were dry, discolored and had a chapped look. The eyes had a raisin look to them and had shades of purple. There were evident signs of rigor mortis. The [REDACTED] stated that it took approximately 20 diaper wipes to clean the child. When the doctor spoke to the mother and father about the death, the [REDACTED] overheard the mother state, "Oh my god I think I killed my baby". The statement the [REDACTED] got indicated that the mother had stated she got up around 7:00 am. The baby was in her crib and the room was cold. The mother put a hooded shirt on the child and turned the heater on. The mother got ready for work and left the home. The father was still in bed. The father fed the baby at 12:00 pm and put the child back in her crib and went to the living room to watch a professional football game. When the father returned to the room to check on the child, the room was very hot and the child was deceased. The child was not sick prior to this incident. The baby

was at the maternal grandfather's and maternal great-grandmother's home the night before. The mother took the child back to the home that evening and the child was very active and alert.

██████████ reported that when the 13-month old came to the ER, the child had dry, blue lips. The eyes were glassy and open. Rigor had set in as evidence by the upper extremities extended and stiff. The pupils were fixed. The nurse took off the diaper and there was a large amount of stool. There was mild bruising on the right wrist. The doctor pronounced the child dead at 5:15 pm. The child's skin was dry, warm to the touch and the rectal temp was 104. The child was only wearing the diaper when ██████████ entered the room. He stated that the amount of time it takes for rigor to set in varies so it is hard to tell exactly how long the child had been dead. The doctor notified the parents and the mother reported to him that there was no history of medical issues. The mother reported that the child was happy in the morning. The father reported that he got up at noon and the child ate and drank like normal. The father went to check on the child after the game and the child was unresponsive.

██████████ from the Hempfield Police Department interviewed the father who reported that the night before the fatality, the child was at the maternal grandfather's home. The maternal grandfather gave the child a bath and fed her. The mother brought the child home around 9:00 pm. The child was happy when she arrived home, laughing and smiling. The father gave the child two sippy cups of strawberry milk and some Gerber Snacks. He got the baby ready for bed between 12:00 am and 1:00am. The room was cold so the father turned on the space heater. The child was put in her pajamas and a sweatshirt. He described the child's bedroom. The crib was on the left hand wall and the space heater is on the right side of the room. The space heater is supposed to turn off when the room gets warm and turn back on when it gets cold automatically. The father reported that he thinks he remembers the mother going to work and thought she said she checked on the baby but he guesses he was wrong. The father reported that the mother left around 9:30 am since she had to be at work by 10:00 am. She works at a restaurant in Jamestown. The father reported that he got up at noon. When he got up, he went to the bathroom and then went into the living room and turned on the TV. He then went into the child's room. The child jumped up and was sucking on an empty sippy cup so the father filled it back up and reset the movie that was playing in the child's room. The bedroom was warm but not hot. The father reported he gave his child a kiss and then closed the door to go watch the game. Once the game was over, the father cleaned up around the home. He did the dishes and cleaned up after the dogs. The father then wondered why he had not heard the child and then thought something was wrong. The father reported he then went into the child's room and it was noticeably hot. The room temperature was around 110 degrees according to the father. When he saw his child he reports that he knew immediately that the child was dead. The child's arms were out stiff and the child's eyes were wide open. He then called 911 after trying to call his grandmother. There were no blankets on the child as they were off to the side of the crib. His wife finally called while he was in the ambulance and she said she was on her way to the ER. The father reports that he thought her mom was picking her up. The father reports that the mother never checked

on the child in the morning and she thought she was fine because she heard her giggling. The father thought that the child had a heat stroke. The father took the sweatshirt off of the child when he found her and was running around the room. He did not change the child's diaper and the child never fussed. He reported that the child eats normally, every two hours. The child's normal schedule is to be up late at night and to get out of bed in the late afternoon.

██████████ then interviewed the mother who reported that she got home the night before the fatality with the child around 9:30 pm. The child was happy when she picked her up. The child was reported to have eaten well all day by the maternal grandfather and the maternal great-grandmother. The mother stated she had a couple bowls of ice cream when she got home. The child had a sippy cup and some snacks at the maternal grandfather's. The mother then got the child dressed for bed. She put her in pajamas and a hoodie that she zipped halfway down. The mother put a movie in and the heater was turned on before she closed the door. The mother reports that she is unsure who turned on the heater. The mother seemed unsure if she in fact put the child in the crib and got the child dressed. She thinks the child went to bed around 11:00 pm but she is not positive. The mother reported that she was not sure how high the heater was turned on. The mother put on the night light and shut the door. She kept the door shut because they have five cats and two puppies, and she did not want the animals in the child's room. The mother thinks she may have given the child a sippy cup of juice in the middle of the night. The father was sleeping in the chair when she went to bed. The space heater is newer, but used. The heater usually faces the TV or door and not on the child. The mother reports that she was up at 9:00 am. She hit snooze a couple times on her alarm so she had to rush to get ready for work. She heard the child making a fuss, but she left the child alone so she would go back to sleep. She let the dogs out and then went to work. The maternal grandmother notified her of what was going on around 5:00 pm because she heard it on the scanner. The maternal grandmother came and picked her up from work and took her to the hospital. The mother reports that the child's appetite is good and she eats just about everything. They do not normally feed her a lot at night. The mother reports that she changes the child's diaper regularly and as often as it needs changed. The mother reported that they "go through diapers like they are going out of style". The mother reported that she works at a restaurant in Jamestown and the father just got a job at ██████████.

On October 17, 2011, ██████████ conducted the autopsy on the deceased Tamera Adams. The autopsy report was completed on October 18, 2011 by ██████████ from Erie upon review of the coroner's findings. The District Attorney's office chose to wait on the findings before any actions/charges.

A review of the record showed that the child was seen at ██████████ for her nine month check up in June and had dropped off the growth chart, as she only weighed 13 pounds at the time. On September 21, 2011 she was seen for her 12-month check-up and weighed 16 pounds. The family had scheduled a recheck for October 21, 2011 due to her slow growth. The child missed two appointments; one in

July 2011 and one at the beginning of September 2011, but was seen as required after the missed appointments up until the child's death. While it was reported the child was "small for her age", there were no documented concerns by the treating pediatric doctors with respect to her care.

On October 17, 2011, there was a cross-check completed by Mercer County CYS on the mother and father and priors were located in Crawford County. It revealed that there was no known current information on mother, father or baby. However, [REDACTED]

[REDACTED] They did not have any other information.

Current Case Status

The autopsy report completed by [REDACTED] stated that the child's cause of death was Environmental Hyperthermia with secondary cause being [REDACTED]. [REDACTED] from the District's Attorney's office was involved with the entire investigation with Mercer County CYS. The investigation is continuing. The agency did not complete a safety assessment as the child is deceased. The agency did not accept the case for service as there were no other children in the home.

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

Act 33 of 2008 requires that county children and youth agencies convene a review when a report of [REDACTED] involving a child fatality or near fatality is [REDACTED] or when a status determination has not been made regarding the report within 30 days of the oral report to [REDACTED]. Mercer County CYS convened a review team in accordance with Act 33 of 2008 related to this report.

Strengths

The case documentation was very thorough and concise. The agency worked very closely with the Mercer County District Attorney's Office. The agency was in direct communication with the hospital staff as well as the coroner and interviews were conducted in a timely manner.

Deficiencies

The agency's [REDACTED] was not completed within 30 days. However, it was mainly due to the results of the autopsy and forensic test to be concluded. The space heater was also sent out to be examined to see if there was a malfunction within the unit.

Recommendations for Change at the Local Level

There were no recommendations for changes at the local level on reducing the likelihood of future child fatalities and near fatalities directly related to this case. The family was not known to the agency until after the death of the child.

Recommendations for Change at the State Level

There were no recommendations for change at the state level.

Department Review of County Internal Report

The agency did not conduct a Multi Disciplinary Team meeting (MDT) since the child or family was not known to the agency within the past 16 months or involved with any community agencies.

Department of Public Welfare Findings

The family was not previously known to Mercer County CYS. There were no prior reports of abuse or neglect that had been reported.

County Strengths

The county agency conducted the investigation in conjunction with the Mercer County DA's Office. It appears that the child's death was due to the negligence of both parents for not properly checking on their child for several hours.

County Weaknesses

There were no areas of weaknesses that were discovered during a review of the case file.

Statutory and Regulatory Areas of Non-Compliance

There were no regulatory or laws that were not in compliance. No Plan of Correction was necessary or citations issued.

Department of Public Welfare Recommendations

The Department has no recommendations to the county in changing their process for this case. The Department recommends that the agency continue to work in conjunction with law enforcement and the District Attorney's Office. There were no practice issues or concerns on how the case was conducted.