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REPORT ON THE FATALITY OF

ARAYA FRANCISQUINI

BORN: January 11, 2010
DATE OF FATALITY: January 2, 2011

FAMILY KNOWN TO: Lehigh County Children and Youth Services

REPORT FINALIZED ON: June 15, 2013

DATE OF ORAL REPORT: 01/02/2011

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 31, 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.

1. Family Constellation:

| <u>Name</u> | <u>Relationship</u> | <u>Date of Birth</u> |
|--------------------|---|----------------------|
| Araya Francisquini | Victim Child (Deceased) | 01/11/2010 |
| [REDACTED] | Mother | [REDACTED] 1978 |
| [REDACTED] | Father of victim child's siblings ([REDACTED]) | [REDACTED] 1976 |
| [REDACTED] | Incarcerated | |
| [REDACTED] | Sibling | [REDACTED] 1995 |
| [REDACTED] | Sibling | [REDACTED] 1997 |
| [REDACTED] | Sibling | [REDACTED] 1998 |
| [REDACTED] | Sibling | [REDACTED] 2000 |
| [REDACTED] | Sibling | [REDACTED] 2003 |
| [REDACTED] | Mother's Paramour | [REDACTED] 1983 |

[REDACTED] is the father of [REDACTED]. The father of the victim child is unknown. [REDACTED] is the father of [REDACTED] who is 4 years old and [REDACTED] who is 2 years old.

Notification of Fatality :

On January 2, 2011, [REDACTED] was notified by the [REDACTED], Allentown, PA that the victim child had multiple medical problems and had been on an [REDACTED]. The mother had reported that she called Emergency Medical Services at 5:48 am as she had heard the low heart rate monitor alarm. Emergency Medical Services arrived at 5:51 am and said that the child was cold and mottled. On arrival to the emergency room of the hospital, the child was cold, mottled and in asystole with pupils fixed and dilated. The child was pronounced dead at the hospital. [REDACTED] this because the child was cold when the Emergency Medical Services arrived at the home and was questioning how long the child was possibly dead before the mother called. [REDACTED] did not report any signs of abuse but was suspicious of the timeframe that the mother provided. The case was [REDACTED] for possible neglect and was processed as a child fatality. The information was provided to the Northeast Regional Office at 7:35 am that day. A supplemental report was received [REDACTED] on January 2, 2011. This report was made by [REDACTED] stating that he believed that the child died due to medical issues and he did not believe that there was any suspicious conduct. [REDACTED] that there won't be any charges filed and that the autopsy will be performed the next day and the final determination will be made after the results of the autopsy.

2. Documents Reviewed and Individuals Interviewed:

The Northeast Regional Office Program Representative reviewed the [REDACTED] case file and the prior case activity of the family. The Program Representative met with the [REDACTED] Supervisor, Caseworker, and Manager regarding the investigation. The Program Representative also attended the Act 33 review meeting at the agency on February 16, 2011 and had the opportunity to speak with the Chief of Pediatrics of Lehigh Valley Hospital and the Lehigh County Coroner regarding their findings. Both expressed that they were surprised that the child lived as long as she did as her medical conditions and prognosis at birth were bleak. The child's initial life expectancy was determined to have been much shorter in duration. Both felt that the child was well cared for and that the [REDACTED] monitor was requested by the mother but was not determined to be medically necessary. [REDACTED] that no matter when the monitor went off, the outcome would have been the same due to the extensive medical conditions and complications of the child.

Case Chronology:

01/02/2011

Childline received the oral report made [REDACTED] St. Lukes's Hospital in regard to the death of the victim child. The concern arose in regard to the timeframes that were provided by the mother in regard to when the monitor alarm went off and when she called Emergency Services. The on call worker of Lehigh County Children and Youth was apprised of the referral regarding the death of the child.

01/02/2011

The Lehigh County [REDACTED] Caseworker responded to the home of the victim child. This was an unannounced home visit. The caseworker met with the mother's paramour and the siblings of the victim child. All of the children were determined to be safe. The mother was still at the hospital where the victim child had been taken. The Preliminary Safety Assessment Tool completed on January 2, 2011 determined the children to be safe. The county on call worker had initially formulated a safety plan with the on call supervisor upon receipt of the call that the mother would not have any unsupervised contact with the children until more information was obtained regarding the death of the child. Upon completion of the safety assessment tool, the determination that the children were safe did not warrant a safety plan. The mother had been interviewed at the hospital by the Lehigh County Caseworker. The caseworker also spoke with law enforcement as well as the county coroner. Therefore, a safety plan was not needed.

01/03/2011

The CY 104 notification form to law enforcement was sent to the Lehigh County District Attorney's office by the Lehigh County [REDACTED] Caseworker. The case was jointly assigned to the [REDACTED] Caseworker and to a [REDACTED] Caseworker. Upon visiting the home, the caseworkers were concerned that the general housekeeping of the home needed some improvement.

02/23/2011

The conclusion of the [REDACTED] safety assessment tool was completed by the Lehigh County Caseworker with a determination that the children were safe. [REDACTED] was completed by the [REDACTED] Caseworker with a determination of [REDACTED]. The child's cause of death was due to complications of her existing medical conditions and deemed to be from natural causes.

03/10/2011

The family service plan was developed by the caseworker with the mother. The services that were to be provided included Lehigh County Children and Youth Services monitoring the case and [REDACTED] for the mother through [REDACTED].

03/31/2011

The case closure safety assessment tool was completed by the Lehigh County Caseworker with a determination that the children were safe. The case was closed as the family had adequate support systems in place and did not warrant the intervention of the agency. The risk assessment was completed with an overall severity of low and an overall risk of low.

Previous Children and Youth Involvement:

Prior to this referral, Lehigh County Children and Youth Services had involvement with the family on six occasions. Most of the referrals were due to chronic issues of lice infestation and housing conditions. The original referral dates back to February 27, 2002 regarding head lice and school absenteeism. One of the children had been [REDACTED] by her father who is currently serving time in a state prison as a result of this [REDACTED]. This incident occurred between November and December of 1995. [REDACTED] was completed on March 3, 2004. The case remained open until 2006 [REDACTED].

There were several other referrals over the years regarding head lice and school truancy and, as a result, the agency provided ongoing services to the family until the issues were resolved. The referral prior to the child's death was on January 4, 2010 due to concerns with lice infestation. Lehigh County Children and Youth assessed the family at that time and referred the family to a community based in home service. The victim child was receiving services from the [REDACTED] from the hospital. Brief services were provided to the family by Lehigh County Children and Youth Services and it was closed on April 26, 2010.

Circumstances of the Child's Fatality:

It should be noted that the mother of the child had learned during her pregnancy with the child that the child would have [REDACTED]

[REDACTED] Cases of this disorder are reported to be fatal within the first year of life.

On January 2, 2011, Lehigh County Children and Youth Services received [REDACTED] regarding the death of the victim child. The report was made [REDACTED] as there were concerns surrounding the time frames that the mother gave in regard to when she realized that the child was in distress and when Emergency Services were called. The report was [REDACTED]. At the time of this referral, Lehigh County Children and Youth Services were not involved with the family.

The mother as well as a sibling and the mother's paramour reported that the child's [REDACTED] had gone off repeatedly throughout the night. They also stated that between 5:00 am and 5:30 am on January 2, 2011, the child's [REDACTED] were going off so the mother decided to call 911 for assistance. [REDACTED] during the holidays and also recently at the emergency room for [REDACTED] issues.

The case had been assigned jointly to a [REDACTED] Caseworker and a [REDACTED] Caseworker. Upon the initial visit to the home, the home was reported to have dirt on the floors and walls and the kitchen area was reported to have been cluttered. The caseworker reported that her feet stuck to the kitchen floor. There were also concerns that the family didn't have any smoke detectors and had a minimal amount of food in the home. Thus, the case was accepted for services to assist the family with their [REDACTED] as well as to monitor the condition of the home. Physicians clarified that housekeeping imperfections did not impact on the child's medical condition. The child's [REDACTED] that the mother was very attentive to the child's medical needs and compliant with medical treatment.

Current / Most Recent Status of Case:

The [REDACTED] was determined by Lehigh County Children and Youth Services to be [REDACTED] as there was not substantial evidence to support the [REDACTED]. The Lehigh County Coroner determined the Cause of Death as the result of the complication [REDACTED] and the Manner of Death as natural causes. Both the [REDACTED] stated that the child lived longer than what was initially expected. In addition to the [REDACTED], the child was [REDACTED].

The criminal investigation was closed by law enforcement with no criminal charges being filed as the death of the child was ruled due to natural causes.

Lehigh County Children and Youth Services assessed that the family was not in need of agency intervention at this time as the family was connected with [REDACTED] where the child received her care. The mother had initiated involvement with [REDACTED] at the time of her pregnancy to assist her with caring for the child's needs and establishing a network. The family advocate worker of the Lehigh County Child Advocacy Center reached out to the family on January 7, 2011 to offer assistance linking the family to [REDACTED] or other support networks. The mother felt that she had her own supports in place and wasn't in need of any assistance. Housekeeping conditions improved throughout agency involvement and this was no longer an issue at case closure.

Statutory and Regulatory Compliance:

The agency completed a family service plan on March 10, 2011 and did not get the mother to sign the plan. The documentation states that they forgot to get the mother to sign. It is unclear as to why the case was opened as the mother had already been involved in [REDACTED]. The home conditions had been resolved and were not addressed in the family service plan as they didn't need to be included. The case was closed on March 31, 2011. It appeared that this was just an issue of completing the necessary documentation at the appropriate times. The agency will be

cited for non compliance relating to the lack of the signature of the mother according to Chapter 3130.61 as well as the lack of documentation regarding the mother's participation in the development of the family service plan and her receipt of a copy of the plan.

Findings:

The agency conducted an Act 33 review on February 16, 2011. The team did not have any concerns or recommendations regarding the agency's handling of the case. They did not feel that the child's death could have been prevented as the child died from natural causes related to complications of her existing medical condition.

The Northeast Regional Office of Children, Youth and Families did find through the review of the current case that the family service plan was not signed by the mother. The [REDACTED] caseworker wrote on the signature line that he forgot to get the mother to sign the family service plan. Also, the family service plan was poorly developed as it appeared to be just a document that was completed purely for compliance purposes and did not serve a valid purpose for the family.

Recommendations:

It is recommended by the Northeast Regional Office of Children, Youth and Families that Lehigh County Children and Youth Services Administration, Quality Assurance and Training Managers review with supervisory and casework staff the importance of the family service plan as a viable, working document with a purpose. It should not be just a piece of paper that needs to be completed. Thus, development with the family and their signature is essential. In this case, the mother stated that she was involved in [REDACTED] and had connections with [REDACTED] since her pregnancy with the child and reported that she was not in need of agency involvement. This was known from the start of the investigation.