



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE Fatality OF:

Jazlyn Leriche

BORN: [REDACTED] 2011
DIED: 02/11/2012

FAMILY KNOWN TO:
Columbia County Children and Youth Services

REPORT FINALIZED ON: 06/19/2013

DATE OF ORAL REPORT: 12/14/12

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))

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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.

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

Family Constellation:

Household Members:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Mother of victim child	[REDACTED]/91
Jazlyn Leriche	Sister of victim child	[REDACTED]/10
	Victim Child	[REDACTED]/11

Non Household Members:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Father of victim child	[REDACTED]/88
[REDACTED]	Maternal Grandfather	[REDACTED]/69
[REDACTED]	Friend of Mother	[REDACTED]/89

Notification of Child (Near) Fatality:

The child was found deceased on 02/11/12 at her mother's residence. [REDACTED] called the police. When the police arrived, the mother reported that the child had a fever the night before and she had been wheezing. The mother did not know the child's temperature because she did not have a thermometer. The mother did not take the child to the hospital because she did not have transportation and planned to take the child the next day.

The mother first reported to the police that she put the child to bed at 10:00pm on 02/10/12 and did not check on her until 8:30am the next morning, 02/11/12. She later told another officer that she had last seen the child at 2:00am, at which time she fed her. The child was found wearing a long sleeved shirt, sweatpants and a fleece sleeper. There was a space heater right next to the child. There were several filled bottles around the child's baby chair and it is believed that the mother propped the bottles.

An autopsy was performed on 02/13/12; the report was received by the agency on 06/20/12. The death certificate was received by the agency on 11/19/12. [REDACTED]

The [REDACTED] death was considered natural. [REDACTED]

[REDACTED] stated that neglect played a significant role in the child's death. Columbia County Children and Youth Services immediately reported this information to [REDACTED] for the County on 12/14/12. The mother was listed as the [REDACTED] due to the child's condition upon death.

Summary of DPW Child (Near) Fatality Review Activities:

The Central Region Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker, [REDACTED], the Supervisor, [REDACTED], and the Agency Director, [REDACTED] on January 11, and 31, 2013. The regional office also participated in the County Internal Fatality Review Team meeting on February 11, 2013 where copies of the medical examiners reports and autopsy were presented. In addition, the county had a local Multidisciplinary Disposition Team (MDT) meeting on 01/02/13.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

Columbia County Children and Youth Services were assessing the one and only referral they received on this family when the child's death occurred. Columbia County Children and Youth Services received a referral on 01/17/12 from the [REDACTED]. The [REDACTED] worker reported concerns with mother's [REDACTED] and stated that mother had a [REDACTED]. The referral source stated that the mother had canceled two appointments in a row with [REDACTED], but allowed [REDACTED] come to the home on 01/17/12. At that time, mother reported to referral source that she took the rest of her [REDACTED] pills (quantity unknown) during a fight with the children's father and that it knocked her out for 18 hours. In addition, mother reported to [REDACTED] worker that she tried to cut herself with a knife but the father took it away so she tried to cut herself with thumbtacks. The referral source was concerned because the father moved out of the home and only the mother was with the children. There was no time given for when the father moved out of the home.

Columbia County Children and Youth Services went out on crisis the day they received the referral, 01/17/12. Mother denied [REDACTED] and denied she had taken medication or tried to harm herself. She appeared stable at that time. Although mother refused to allow the caseworker into her home, citing a messy house, she brought both children outside for the worker to see. The worker saw nothing to cause concern about the children's health. During the visit, mother contacted her father and the caseworker noted that he appeared to be a good support for her. The mother also had a friend at her home that she identified as a good support. Mother agreed to go to all of her appointments with her [REDACTED]. She also said she was getting her [REDACTED].

the next day. The mother said she had the phone number for [REDACTED] and would contact someone if she felt [REDACTED].

The Columbia County Caseworker stopped at the home the next day, 01/18/12. The children were at maternal grandfather's home, but the mother was at her home. She gave the caseworker a letter signed by [REDACTED] which stated that she was a capable parent, she brought the children in [REDACTED], she called [REDACTED] when needed. The letter also stated that the [REDACTED]. The caseworker eventually learned that the last time the [REDACTED] saw the children was on 01/14/12, approximately one month prior to the victim child's death. [REDACTED]

The caseworker went out two more times (02/06/12 and 02/08/12) leading up to the death of the child, but did not find anyone home.

The agency had two referrals on the mother when she was a child. It was reported on 01/31/06 that the mother was being left alone after threatening to hurt herself and that her step-mother yelled at and hit her. The family denied any inappropriate discipline and the caseworker felt there was more concern with the [REDACTED] as she had been cutting herself. The family was receiving [REDACTED] and the case was closed on 03/31/06 when things appeared to stabilize.

It was reported on 04/20/07 that the mother's cousin sexually abused her two years prior to receipt of the report. The incident had already been reported to the police but charges were never filed. The mother also reported that two other teenage boys pressured her to have sexual intercourse. The maternal grandfather was to report those incidents to the police, but the mother did not want to press charges and the agency believes that charges were never filed.

At the time of death of the victim child her sibling went to live with the maternal grandfather per a safety plan developed between the mother and Columbia County Children and Youth Services and the maternal grandfather. The maternal grandfather now has custody of the sibling. Mother sees the child with supervision by the maternal grandfather, [REDACTED].

Circumstances of Child (Near) Fatality and Related Case Activity:

The child was found deceased on 02/11/12 at her mother's residence. [REDACTED] called the police. [REDACTED], When the police arrived, the mother reported that the child had a fever the night before and she had been wheezing. The mother did not know the child's temperature because she did not have a thermometer. The mother did not take the child to the hospital because she did not have transportation and planned to take the child the next day.

The mother first reported to the police that she put the child to bed at 10:00pm the night before and did not check on her until 8:30am the next morning. She later told another officer that she had last seen the child at 2:00am, at which time she fed her. The child was found wearing a long sleeved shirt, sweatpants and a fleece sleeper. There

was a space heater right next to the child. There were several filled bottles around the child's baby chair and it is believed that the mother propped the bottles.

An autopsy was performed on 02/13/12; the report was received by the agency on 06/20/12. The death certificate was received by the agency on 11/19/12. [REDACTED]

The death was considered natural. The [REDACTED] stated that neglect played a significant role in the child's death. Columbia County Children and Youth Services immediately reported this information to [REDACTED] this as a [REDACTED] report for the County. The mother was listed as [REDACTED]

The agency later learned that the father had been living in the home until two weeks prior to the child's death and reported that he had no concerns about the children or the care they received from the mother. The father confirmed that mother called him the night before the child's death as she did not have a thermometer, but he was unable to provide her with one.

The mother denied knowing that her child was [REDACTED]. The mother had no explanation for the child's condition at the time of her death. Columbia County Children and Youth Services [REDACTED]

Current Case Status:

At the time of death of the victim child, her sibling went to live with the maternal grandfather per a safety plan developed between the mother, Columbia County Children and Youth Services and the maternal grandfather. The maternal grandfather now has custody of the sibling.

The case was opened for Protective Services on 03/16/12 and closed on 02/11/13 as the maternal grandfather received full custody of the surviving sibling. Mother has supervised visits as mutually agreed upon between the parties with the child.

The mother sees a [REDACTED]. Mother has worked with him since she was a teenager. Although at times her attendance was inconsistent, she still enjoys a relationship with [REDACTED]. Mother receives [REDACTED] management from her primary care physician, [REDACTED].

A new referral on the mother was initiated on 03/01/13 as she is pregnant and due in May 2013. The mother moved during the first week of April 2013 to Luzerne County in order to be closer to the father of the unborn child. A referral has been made to Luzerne County Children and Youth Services and written material will be sent to the agency as of April 5, 2013. The due date is May 24, 2013.

The [REDACTED] police have been involved with the case since the day of the death of the minor child. [REDACTED] continues

to talk to the Assistant District Attorney, [REDACTED], about the situation. To date, no charges have been filed by the District Attorney's Office.

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

- Strengths:
 - The agency responded immediately upon receipt of the initial referral.
 - Safety of the surviving sibling was immediately assured after the death of the victim child.
 - The agency worker made contact with service providers involved with mother.
 - The agency worker was diligent about attempting to keep mother on task regarding her [REDACTED] and children's appointments.
 - The agency worker provided mother with appropriate [REDACTED] telephone numbers.
 - The agency opened a new case on the mother who is pregnant and has followed up by making a referral to the county to which the mother moved.

- Deficiencies:
 - The agency worker did not get into the family home due to lack of cooperation by the mother.
 - The agency worker did not follow up to make sure mother had filled prescriptions.

- Recommendations for Change at the Local Level:
 - Add casework staff to the agency such that workers are able to spend more time with families on a more frequent basis in order to more thoroughly assess for safety of children.

- Recommendations for Change at the State Level:
 - Additional funding for Nurse Family Partnership in order for children's development to be tracked in the home.
 - Additional funding to county agencies in order to hire more staff.
 - Additional funding provided to Family Centers so that children could be assessed for Failure to Thrive.

Department Review of County Internal Report:

The Central Region Office of Children, Youth and Families (OCYF) Program Representative received and discussed the report with county on 02/11/13. OCYF concurred with the agency's rapid response to the initial intake as well as the safety plan that was immediately implemented for the surviving child. Concern was expressed that the agency was planning to close the mother's case prior to the birth of the new baby. The agency decided to open a new referral on the mother in anticipation of the birth of the new child.

Department of Public Welfare Findings:

- **County Strengths:**
 - The investigation completed by the agency was conducted in a timely fashion and in collaboration with law enforcement services.
 - The agency continues to maintain contact with law enforcement regarding the outcome of their investigation.
 - The agency developed an appropriate safety plan for the surviving child immediately upon learning of the death of the victim child.
 - Safety assessment and planning was completed in a thorough fashion. The safety plan was timely, inclusive of family/care providers input and signatures.
 - The agency has alerted the county hospital of the impending birth of another child to this mother.
 - The agency opened a new referral on the mother due to the impending birth of another child and made appropriate referrals when the mother moved from their county.

- **County Weaknesses:**
 - None noted.

- **Statutory and Regulatory Areas of Non-Compliance:**

There were no statutory or regulatory compliance issues noted.

Department of Public Welfare Recommendations:

The agency should continue with rapid assessment and appropriate response to all allegations of child abuse and neglect. The agency should continue to maintain close collaboration with law enforcement regarding all appropriate referrals.

Nurse Family Partnership staff should assess the health, safety and welfare of all children in the home, not only their assigned child. In this case NFP was assigned to the older child and did not assess or address concerns regarding the younger, victim child.