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REPORT ON THE DEATH OF

Keira Ellinger

BORN: 02/11/2008

DATE OF FATALITY: 05/07/2009

FAMILY NOT KNOWN TO: SCHUYLKILL COUNTY CHILDREN AND YOUTH SERVICES (SCCYS)

REPORT FINALIZED 02/16/2010

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.

1. Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Mother's Paramour	Unknown
[REDACTED]	Mother	[REDACTED] 93
Keira Ellinger	Victim	12/11/08
[REDACTED]	Mother's Paramour/Perpetrator	[REDACTED] 79

Notification of Near Fatality:

The Victim Child (VC) was brought to the [REDACTED] by the mother and [REDACTED]. The VC was transferred to a [REDACTED]. The VC was [REDACTED]. The VC was not breathing and did not have a heart beat. Upon admission to the hospital a heart beat was reestablished and the VC was placed on [REDACTED]. The VC was listed in [REDACTED] condition. It was noted that the VC had scratches on her neck and head area. A CAT scan revealed the VC had [REDACTED]. The VC arrived by ambulance and the parents did not arrive to the hospital by the time of the report.

2. Documents Reviewed and Individuals Interviewed:

NERO reviewed the file including interviews and medical reports.

Case Chronology:

05/05/09 SCCYS Caseworker (CW) received a referral from [REDACTED]. The initial report had very little information (VC birth date and reporting source information only). As a result, the CW contacted [REDACTED]. At that time the reporting source stated the VC was transferred from [REDACTED]. Upon arrival the VC [REDACTED]. The VC had bruises and scratches on her neck and head [REDACTED]. The CW contacted the on-call supervisor and the Pottsville police. The CW then contacted [REDACTED]. The [REDACTED] reported the VC's mother arrived in the emergency room with an unidentified [REDACTED] male and screamed for help. The VC was covered in vomit. The CW called [REDACTED] to obtain information from the mother (does she have other children, who had access to the VC, etc.). The Pottsville Police Department contacted the CW with information regarding the possible identity of the [REDACTED] male. The name which was provided was consistent with the information the mother provided regarding who had access to the VC.

05/06/09 The CW assigned the investigation and a coworker traveled to [REDACTED]. Two police officers from the Pottsville Police Department met them there. The CW spoke to the treating physicians at [REDACTED].

[REDACTED] The CW also interviewed the VC's mother and perpetrator. The [REDACTED] denied injuring the VC.

05/07/09 VC pronounced dead at 4:45 p.m. The agency receives partial medical records.

05/07/09 CW contacts [REDACTED] probation officer.

05/08/09 An autopsy was performed.

05/15/09 The VC's mother was re-interviewed. She was consistent in reporting that she went to the store to buy the VC Oragel as it appeared he was teething, when she left the child was fine, the [REDACTED] called her and reported there was something wrong with the child. She returned and found the VC unresponsive and sought help.

06/24/09 The agency requests additional medical records from the [REDACTED].

06/25/09 The [REDACTED] failed a polygraph examination but did not admit to causing the VC's injuries.

07/02/09 [REDACTED] [REDACTED].

08/31/09 The VC's mother completed a polygraph examination. It was reported that "she did not do well". It was reported that "she did well on the pre-test but the actual test she didn't do so well, but she could provide explanations". The examiner did not indicate that he felt she was lying, and he could not rule out grief as a cause for her performance.

09/2/09 A copy of the autopsy results were obtained. This stated that the child died of blunt force trauma to the heads, inconsistent with accidental trauma, homicide.

11/04/09 The case was presented to the Attorney General's Medical/Legal Advisory Board (police, physicians, etc) in Harrisburg to determine whether there was enough evidence to proceed with charges. The recommendation was made that there was enough evidence.

Previous CY involvement:

The Family was not known to SCCYS. However, the mother of the child and the perpetrator had involvement with the agency when they were minors. [REDACTED] [REDACTED] due to his mother's drug and alcohol issues.

Circumstances of Child's Near Fatality:

On May 5, 2009 the mother of the VC had been at the store to purchase medicine because the VC was teething. Upon returning to her residence, the mother's paramour stated that the VC had vomited. The mother realized something was wrong with the VC and called an ambulance. The VC was not breathing and did not have a heart beat. The VC subsequently died as the result of her injuries (subdural bleeds/bilateral and cerebral edema of the brain).

Current / most recent status of case:

[REDACTED]

- The case was not accepted for services as there aren't any other children in the home.
- Criminal charges have not been filed in this case. The agency reports there was a meeting recently between the coroner, [REDACTED] and the District Attorney's office to determine if a more accurate time line regarding the injuries could be established to determine whether or not the perpetrator was the only person with access to the child at the time the VC was injured.

Services to children and families:

The agency did not provide any services or referral the family for any services. However, the record indicated the VC's mother did receive [REDACTED]
[REDACTED].

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. This case was not known to the agency prior to the report of [REDACTED].

NERO Findings:

The agency did not complete a risk assessment at the completion of the investigation. Although there were not any other children residing in the home, a risk assessment is still required. Likewise, the agency reports the assessment was completed during the investigation period and printed/signed several months later when the dictation was complete. However, the assessment was not signed by a supervisor and was dated several months after the investigation was closed.

NERO Recommendations:

The NERO recommends the agency review their policy for completion of Risk Assessments and complete Risk Assessments as required by regulation.

Statutory and Regulatory Compliance issues:

- An immediate safety assessment was done regarding this child. Because the child was immediately hospitalized, there was no need for a safety plan.
- The investigation was completed in a timely manner. All letters and CY104 (Notice to Law Enforcement Officials) were sent in a timely manner, however as previously noted the Risk Assessment was not completed as required by regulation.
- All parties were interviewed.
- There were no other children living in the family, therefore the family was not accepted for services.