



## **REPORT ON THE FATALITY OF:**

**JERAMYAH RIVERA**

**Date of Birth: 05-30-2013**

**Date of Death: 05-01-2014**

**Date of Oral Report: 05-01-2014**

**FAMILY KNOWN TO:**

**BERKS COUNTY CHILDREN AND YOUTH SERVICES**

**REPORT FINALIZED ON:**

**7-07-2015**

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.  
(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, DHS 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. Berks County convened a review team on June 10, 2014 in accordance with Act 33 of 2008 related to this report.

**Family Constellation:**

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Rivera, Jeramyah	Victim Child	05-30-2013
[REDACTED]	Mother	[REDACTED] 1994
[REDACTED]	Father of [REDACTED]	Adult
[REDACTED]	Sibling	[REDACTED] 2010
[REDACTED]	Mother's Paramour	[REDACTED] 1989
[REDACTED]	Sister of Paramour	Unknown
[REDACTED]	Father of Paramour	[REDACTED] 1962
[REDACTED]	Brother of Paramour	[REDACTED] 1987

**Notification of Child Fatality:**

On May 1, 2014, the victim child's mother called 911 due to her child's unresponsiveness. The victim child arrived at the Reading Hospital via ambulance without a heartbeat. The hospital staff attempted to revive the child unsuccessfully. When the victim child was brought in, the paramour said that he found the child 15 minutes earlier non-responsive. As per the doctor, the victim child was unresponsive longer than 15 minutes. The victim child was stiff already and blue, rigor mortis had already set in. The coroner thought the victim child had been dead longer than approximately an hour.

**Summary of DHS Child Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families (OCYF) obtained and reviewed all current and past case records pertaining to the [REDACTED] family. Follow up interviews were conducted with the Caseworker, [REDACTED]; Supervisor, [REDACTED] and the Agency [REDACTED] Administrator, [REDACTED]. The Southeast Regional Office also participated in the County Internal Fatality Review Team meeting on June 10, 2014 where copies of the medical examiner's reports were presented.

**Children and Youth Involvement Prior to Incident:**

Mother was involved with Berks County Children and Youth Services (BCCYS) and Lancaster County CYC as a child from 12-16-2008 and remained in BCCYS custody until 19 years old. However, none of her children were in placement.

- December 16<sup>th</sup> 2008 to December 31<sup>st</sup> 2008 Mother was placed in a foster home through [REDACTED] in [REDACTED] Pa after [REDACTED].
- December 31<sup>st</sup> 2008 to January 12<sup>th</sup> 2009 Mother was placed in a kinship home with her maternal Aunt in [REDACTED], Pa.
- From January 12<sup>th</sup> 2009 to February 9<sup>th</sup> 2009 Mother was placed in a [REDACTED] Foster home in [REDACTED], Pa.
- February 9<sup>th</sup> 2009 to July 7<sup>th</sup> 2009 Mother was also placed in a [REDACTED] Foster home in [REDACTED], Pa.
- July 7<sup>th</sup> 2009 to August 21<sup>st</sup> 2009. Mother was placed in [REDACTED] Foster home in [REDACTED] Pa.
- August 21<sup>st</sup> 2009 to September 4<sup>th</sup> 2009. Mother was in a Berks County Youth Shelter care in [REDACTED], Pa.
- September 4<sup>th</sup> 2009 - to present. Mother was in a [REDACTED] foster home in [REDACTED] Pa. until [REDACTED] February 25<sup>th</sup> 2014.

**Circumstances of Child Fatality and Related Case Activity:**

Three weeks prior to the incident the child was seen by his pediatrician at the Reading Hospital for a head injury after a fall as described by the mother.

On May 1, 2014, the victim child arrived at the Reading Hospital without a heartbeat. The hospital staff attempted to revive the child unsuccessfully. When the victim child was brought in, the paramour said that he found the child 15 minutes earlier non-responsive. As per the examining physician, this victim child had to have been unresponsive longer than 15 minutes. The victim child's body was already stiff and blue. Rigor mortis had already set in. Mother and her paramour both stated that the child was sick on Wednesday night and that he had thrown up all his food. They also stated that the child was not himself on Thursday and that he appeared sleepy. Mother indicated that she tried to feed him cereal. He ate a little and drank some juice and water; however, he kept spitting up throughout the day.

The mother said they had moved back from [REDACTED] to Berks County. She had a job interview at noon on May 1, 2014. The family accompanied her to the interview; however, the children stayed with [REDACTED] in the car. After the interview they went home and upon their arrival, she took [REDACTED] to the park and left Jeramyah home with [REDACTED]. Upon her return, [REDACTED] told her that the child threw up twice and he cleaned him up and that he was in his crib sleeping. Mother went downstairs to get dinner ready. While cooking, [REDACTED] went upstairs to check on the victim child. He came down the steps and said something was wrong with child. He asked the mother to call 911 while he performed CPR on child.

**Current Case Status:**

At this point the coroner believes that the death of the child is “not from natural causes” as there are unexplained bruises around the child’s abdomen and skull that are not consistent with resuscitation, but may be consistent with blunt force trauma. As of July 18, 2014, ██████ confessed to inflicting injuries by squeezing the child’s abdomen forcefully because he was crying. ██████ admitted that injuries to the victim child were inflicted by her in Lancaster County prior to moving to Berks County. Third degree homicide charges were filed against ██████ She is incarcerated because of flight risk.

**County Strengths and Deficiencies and Recommendations for Change as Identified by the County’s Child Fatality Report:**

Strengths: Berks County conducted a thorough ██████.

- Deficiencies: The welfare of the children was not properly addressed by BCCYS. There were many inconsistencies of events that occurred which were not sorted out.
- Recommendations for Change at the Local Level: Mothers in care with children should be properly monitored.
- Recommendations for Change at the State Level: Mothers in care with children should be properly monitored.

**Department Review of County Internal Report:**

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current and past case records pertaining to the ██████ family. Follow up interviews were conducted with the Caseworker ██████ the Supervisor ██████ and the Agency ██████ Administrator ██████. The regional office also participated in the County Internal Fatality Review Team meetings on June 10, 2014 where copies of the medical examiner’s reports were presented

**Department of Human Services Findings:**

County Strengths:

- Berks County provided services to the mother from 2002 until she was 19 years old. BCCYS was in compliance with statutes and regulations. A safety plan for the victim child’s sibling was put in place and for other children residing in the household at the time of the fatality.

County Weaknesses:

- The welfare of the children was not properly addressed by BCCYS. Jeramyah missed 10 of 11 well baby checkups while his mother was in placement. The county explained that the teen mother was responsible for the children's medical appointments. No oversight appears to have been provided of the mother's care of the children by the county or provider. During the Act 33 review, it was evident that the county caseworker and supervisor were not assessing the safety and wellbeing of the young children while the mother was in placement.
- There were many inconsistencies of events that occurred which were not sorted out.

Statutory and Regulatory Areas of Non-Compliance

- None identified

**Department of Human Services Recommendations:**

Mothers in care with children should be referred to a mother /baby program for services. The program description should clearly address how the mothers' parenting is being assessed and monitored. If the mother is not meeting certain identified goals, such as routine medical care, then the agencies must be prepared to intervene or assist the mother with these tasks.