pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Malayna A. Wills

Date of Birth: 05/30/2016
Date of Death: 12/20/2016
Date of Report to ChildLine: 01/19/2017
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Luzerne County Children and Youth

REPORT FINALIZED ON:
07/06/2017

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. Section 6349 (b)

Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a 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.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Luzerne County did not convene a review team. The investigation [redacted] within 30 days; therefore, the county was not required to convene a review team.

Family Constellation:

First and Last Name	Relationship	Date of Birth
Malayna A. Wills	Victim Child	05/30/2016
[redacted]	Biological Mother	[redacted]1991
	Biological Father	[redacted]1990
	Maternal Aunt	[redacted]2005
	Sibling	[redacted]2012
	Maternal Step-Grandfather	[redacted]1961
	Maternal Grandmother	[redacted]1967

Summary of OCYF Child Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families (NERO) reviewed the case record pertaining to this incident. The county agency was not required to convene an Act 33 review team meeting due to the investigation being [redacted] within 30 days.

Children and Youth Involvement prior to Incident:

The family did not have any prior history with Luzerne County Children and Youth prior to this incident.

Circumstances of Child Fatality and Related Case Activity:

On 01/19/2017, Luzerne County Children and Youth Services received a referral [redacted] alleging abuse of the victim child. The victim child had died on 12/20/2016; however, there was no report alleging that the death was due to suspected abuse until this report was received by LCCYS on 01/19/2017. The referral source alleged that there was substance abuse in the home, that there were 14 dogs in the home and that Crystal Meth was being used in the home by the mother and maternal grandmother. Also alleged was that the maternal

grandmother drinks all day and becomes crazy and violent and that all of the adults in the home use drugs. The referral source further reported that the adults are all passed out and no one is watching the children in the home, that there was an infant that passed away in the home because [redacted] passed out on the couch with the baby in her arms and the child was smothered by [redacted] The referral source alleged that the mother was intoxicated at the time of this incident and she passed out because she was high.

Upon receipt of the referral, an unannounced home visit was conducted by LCCYS [redacted] During the walk-through of the home, the parent's bedroom had a strong smell of marijuana. Mother, father and maternal grandmother denied drug usage. All members of the household were requested to go for drug screens; mother and maternal grandmother's screens came back positive for drugs. The family agreed to a safety plan that required that the children were not cared for by any of the adult household members. The plan was revised on 01/24/2017 that required the maternal step-grandparent resume care of both children, the victim child's 11-year-old maternal aunt and the victim child's sibling. [redacted] met with LCCYS. [redacted] stated that maternal grandmother had gone out with friends to dinner the day prior to LCCYS coming out to the home. One of the friends said "take this and it will make you feel better". [redacted] suggested it was the one and only time. Maternal grandmother tested positive for Crystal Meth; [redacted] also stated that the maternal step-grandfather was unaware of this incident.

On 02/02/2017, father was found to be a safe caretaker for his son and he resumed caring for him.

[redacted] participated in an interview regarding the victim child's death. [redacted] stated that the victim child was born premature at 37 weeks. [redacted] stated that the child's sugar was low at birth but that was it. On the day of the victim child's death, [redacted] woke up and everything was normal; they played, had tummy time and, around 2:45PM, they took a nap. [redacted] laid on the couch with the victim child. At 4:00PM, father came home and woke them up. [redacted] stood up and "vile" poured out of the victim child's mouth onto [redacted] pants and victim child was limp. [redacted] started doing cardiopulmonary resuscitation (CPR) immediately and 911 was called. The first responder showed up and continued doing CPR until the ambulance got there. [redacted] stated that the [redacted] ambulance was not available so they had to wait 45 minutes for the [redacted] ambulance. [redacted] stated that the only people in the home at the time of the incident was the sibling, the maternal aunt, mother and the victim child. [redacted] stated that they called the maternal grandmother and maternal step-grandfather to tell them what happened. [redacted] stated that the maternal grandmother was on the turnpike when [redacted] called her and made it back to the house before the ambulance got there. [redacted] took the victim child's sibling upstairs while all of this was going on so they weren't exposed to it. [redacted] reported that, at the hospital, they continued working on the victim child for 30 minutes then came out and told [redacted] that the victim child had died. [redacted]

[redacted] also stated that the coroner had told her that asphyxiation and suffocation were ruled out but that they had to wait for the pathology report.

The father participated in an interview. He stated that, on the day of the incident, he woke up and went to work at 4:30AM. He came home at 4:45PM and found [redacted] and victim child sleeping on the couch. Father stated that they looked like they were sleeping. He woke [redacted] up; [redacted] stood up and the victim child looked limp and spit up vomit. Father put her on the floor and gave her CPR. Father left to pick up his dad to see if he could help. By the time he got back, the ambulance was already there. The ambulance transported the victim child to the hospital and, when they got there, they put them in a conference room and told them that the victim child didn't make it. Father stated that he had no clue that the maternal grandmother was using Crystal Meth; however, he did know that [redacted] was using marijuana but she had never smoked it prior to the victim child's death. He denied knowing how it could have showed up in his system other than driving the car while [redacted] was smoking it. Father denied that [redacted] was under the influence of any drugs when the victim child died. He denied that she used any drugs other than [redacted] Father reported that [redacted] was sleeping with the victim child; however, there was distance between them and victim child's nose and mouth were not covered and [redacted] was not on the child in any way when he came home and saw them sleeping on the couch. Father did confirm that the maternal grandmother has an alcohol problem and gets confrontational when she drinks but that the maternal step-grandfather is "as straight and narrow" as they come.

The maternal step-grandfather was interviewed. He stated that he was not aware of his wife's drug use and that he has never noticed anything different in his wife's behavior. He was not home at the time of the incident.

LCCYS contacted law enforcement who reported that mother was willing to go for a drug screen the day of the victim child's death; however, law enforcement did not feel it was necessary. The assigned law enforcement investigator reported to LCCYS that he did not feel there was any foul play involved and no criminal charges were being filed.

An autopsy was performed on the victim child. The death certificate was signed on 02/07/2017; the manner of death was ruled accidental while the cause of death was ruled Sudden Unexplained Infant Death Syndrome. The death certificate also stated that the injury occurred from co-sleeping [redacted]

LCCYS [redacted] the case on 02/13/2017, the children were determined to be safe in their home and the case was closed. [redacted]

Summary of County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:

- Strengths in compliance with statutes, regulations and services to children and families;

  The case was [redacted] in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

- Deficiencies in compliance with statutes, regulations and services to children and families;

  The case was [redacted] in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

  The case was [redacted] in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies;

  The case was [redacted] in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

  The case was [redacted] in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

Department Review of County Internal Report:

The case was [redacted] in less than 30 days; therefore, neither an Act 33 team meeting nor written report was required.

Department of Human Services Findings:

- County Strengths:

  LCCYS consulted with law enforcement regarding the investigation and their findings prior to concluding the case.

- County Weaknesses:

  There were three discrepancies in the case file that were not addressed by LCCYS:

  1) During [redacted] interview, it is documented that she stated that she immediately began CPR on the victim child. During father's interview, it is documented that he stated he began CPR on the victim child.

  2) The death certificate is contradictory in that it states the cause of death as Sudden Unexplained Infant Death Syndrome; however, it states the manner as accidental and that the injury occurred from co-sleeping [redacted]

  3) [redacted] stated that she heard the child victim child cough then get quiet and she went to check on the victim child and found the victim child unresponsive. It does not appear that this contradictory statement was addressed with [redacted]

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:

  There were no Statutory or Regulatory areas of non-compliance identified as a result of this review.

Department of Human Services Recommendations:

It is recommended that all records (medical, death certificates, witness statements etc...) be reviewed in their entirety in order for discrepancies to be addressed prior to case determinations being made.

It is recommended that safe sleep education, including the dangers of co-sleeping with young children, be provided to every family with young children whom referrals have been received by child welfare agencies. In addition, it is recommended that public service and community announcements be continued in order for safe sleep education, and the dangers of co-sleeping with young children, be provided to all families with young children.