pennsylvania
DEPARTMENT OF HUMAN SERVICES

# REPORT ON THE FATALITY OF:

## SHIARA GUZMAN LOZADO

**Date of Birth:** 12/02/2016
**Date of Death** 05/21/2017
**Date of Report to ChildLine:** 05/18/2017
**CWIS Referral ID:** [redacted]

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

Berks County Children and Youth Services

**REPORT FINALIZED ON:**
01/12/2018

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.

Berks County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 06/06/2017.

## Family Constellation:

| First and Last Name: | Relationship: | Date of Birth |
|---|---|---|
| Guzman-Lozado, Shiara | Victim Child | 12/02/2016 |
| [redacted] | Mother | [redacted]1996 |
| [redacted] | Father | [redacted]1993 |
| [redacted] | Sibling | [redacted]2014 |
| [redacted] | Mother's paramour | [redacted]1998 |
| * [redacted] | Maternal Uncle (MAU) | unknown |
| * [redacted] | Wife of MAU | unknown |
| * [redacted] | MGM | unknown |
| * [redacted] | PGM | unknown |

* Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

## Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed current and past case records pertaining to the [redacted] family. There was an Act 33 Review on 06/06/2017. The case was determined to be [redacted] on 07/07/2017 [redacted] There is no current criminal investigation because the perpetrator committed suicide on 05/24/2017.

## Children and Youth Involvement prior to Incident:

The family was not known to Berks County Children and Youth prior to this incident.

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

On 05/18/2017, the child was taken to Reading Hospital, for what was reported to be seizure activity. The child was then transported to the Hershey Medical Center, [redacted] The mother left her paramour alone with the child between 9:30AM and 10:00AM. This was the first time she left the child alone with the paramour. The mother left the home to have her car serviced. The paramour insisted that the mother leave the infant child home with him. The mother took her 3-year-old daughter with her, because the 3-year-old did not like the paramour, and did not want to stay home with him. The mother reportedly called home several times while she was out, to check on the child. At one point, the paramour did not answer the phone. The mother returned home shortly after that. When the mother returned home, the paramour came downstairs carrying the child, who was purple and unresponsive. The paramour said that he put the child down for a nap around 12:00PM and then checked on the child again around 3:00PM, at which time the child was purple and unresponsive. The paramour did not call 911, nor did he call the mother. The mother arranged for the maternal uncle and his wife to care for the 3-year-old sibling while she went to the hospital with the infant. When the paramour arrived at the hospital, he and the father got into a physical altercation in the parking lot of the hospital. Law enforcement had to be called.

On 05/21/2017, the child was pronounced brain dead at the Hershey Medical Center. [redacted]

Law enforcement interviewed both biological parents, who both denied causing harm to the child. Berks County Children and Youth Services (BCCYS) caseworker interviewed the mother, at which time she stated the paramour had been rough with her 3-year-old in the past, which is why the mother had never left the 3-year-old alone with the paramour prior to the day of the incident. The mother stated the biological father visits his children, but had no contact with the children on the date of the incident.

On 05/24/2017, an autopsy was conducted at Reading Hospital. A determination was made that there was no evidence of systematic or long term physical abuse. The child died of severe hypoxic ischemic brain injury and bilateral subdural bleeds. Circulation to the brain was lost due to severe swelling and herniation into brainstem. There were severe retinal hemorrhages with splitting of the retinal layers. Injuries were consistent with violent shaking. A skeletal survey after the child was declared brain dead showed no fractures.

On 05/27/2017, the mother was informed that [redacted] had committed suicide [redacted] by hanging himself [redacted] This was believed to have occurred on 05/24/2017.

On 05/29/2017, the parents spoke with a caseworker, who they informed of their plan to relocate to Florida. The parents stated that they were not planning to live

together, and that they were going to reside with their respective parents with the hopes of reconciling in the future.

On 05/30/2017, the 3-year-old returned to Florida to live with the paternal grandmother, until the mother completed her relocation in Florida. The agency referred the case to Polk County in Florida upon the parents' relocation. It was noted that at the time of the move, the mother was pregnant with a due date of 12/18/2017. The father of the unborn child was the perpetrator.

On 07/07/2017 Berks County Children and Youth Services [redacted] the referral [redacted] naming [redacted] as the perpetrator.

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

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

  Berks County convened a review team on 06/06/2017, in accordance with Act 33 of 2008. There was cooperation between law enforcement, Children and Youth Services, and medical providers.

  Safety plans were initiated promptly.

  Mother, father moved to Polk County Florida with appropriate supports in place

  The perpetrator's nieces, who found his body after he hung himself, have access [redacted] services.

  Local Law Enforcement responded to an altercation at the Reading Hospital Medical Center (RHMC) between the father and the paramour in the hospital parking lot. [redacted] also followed inquire about the status of the child and the investigation.

  There is concern that the mother knew the 3-year-old was afraid of the paramour [redacted] but allowed the infant to be alone with him.

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

  [redacted]

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

Continuing education and reinforcement of need for medical providers to complete [redacted] and file when abuse is suspected was again reviewed. Delay in reporting hindered investigation by Law Enforcement.

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

  As above, education and reinforcement of prompt reporting.
  Discussed complexity of providing lifesaving measures for victim in ER, preparing for transport, addressing needs of the family, and the fact that the required [redacted] paperwork is sometimes overlooked. The 24-hour presence of a hospital-based social worker to assist in cases, such as this, would improve the reporting process. Completion of [redacted] is sometimes delayed or not completed when a child is transferred to another facility because it is assumed that providers at the receiving facility will complete the paperwork.

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

  None at this time.

**Department Review of County Internal Report:**

The Department received and reviewed the county's internal report and concurs with the county's report, findings and recommendations.

**Department of Human Services Findings:**

- County Strengths:

  The investigation was thorough, citing all of the interactions with family, medical staff, the Police department, and extended family members.

- County Weaknesses:

  None

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

  None

**Department of Human Services Recommendations:**

There are no additional recommendations, at this time.