pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Zoey Bernier

Date of Birth: 08/17/2012
Date of Death: 07/30/2019
Date of Report to ChildLine: 07/30/2019
CWIS Referral ID: [redacted]

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

Lebanon County Children and Youth Services

REPORT FINALIZED ON:
02/14/20

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.

Lebanon 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 August 27, 2019.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth:
Zoey Bernier	Victim Child	08/17/2012
[redacted]	Half-sibling	[redacted]2015
	Half-sibling	2016
	Biological Mother	1993
	Mother's Paramour	1993
	Father of Half-siblings	1994
	Maternal Grandmother	1968
	Maternal Aunt	1989

* 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 Central Region Office of Children, Youth and Families (CROCYF) obtained and reviewed case records pertaining to the family, which included medical records and the agency casework dictation that outlined contact with the family. CROCYF participated in the Act 33 meeting with the Multi-Disciplinary Team (MDT) on 08/27/2019 to review and discuss case information. Ongoing discussions were conducted with the Lebanon County Children & Youth Services (LCCYS) staff.

Summary of circumstances prior to Incident:

The family had no prior involvement/history with LCCYS.

Circumstances of Child Fatality and Related Case Activity:

On 07/30/2019, a report was received concerning the death of the victim child (VC) who was brought to the emergency room (ER) by emergency medical services (EMS). The child had finger sized bruises on her head, face, torso, arms, legs, feet and fingers. The cause of death was not known but [redacted] due to significant bruising. [redacted] the child was left in the care of [redacted] while [redacted] went to work. [redacted] that the child was reporting having difficulty breathing and complained of chest pain. [redacted] left work and the child was unresponsive by the time [redacted] arrived home. Cardiopulmonary Resuscitation (CPR) was initiated and EMS was called. The bruising was reported to have been caused by [redacted] the child's activities. [redacted] were received reiterating that the victim child was found to have been in cardiac arrest, have bruising on the body, and was transported to the emergency room. [redacted] also confirmed the VC [redacted] An autopsy of the victim child was ordered to determine cause of death and was conducted 07/31/19.

The Agency immediately responded to [redacted] home along with law enforcement to initiate an investigation. It was learned that the there was video footage in the home from the home security camera. The footage was viewed, after obtaining a search warrant, and did not display concerning behaviors or any acts that would have contributed to the child's death. [redacted] attributed the bruising to be from [redacted] was actively involved [redacted] at the time of incident. [redacted] agreed to provide care and supervision of the children. A walk through of [redacted] did not reveal any health or safety concerns. [redacted] The following day, the VC had been outside playing, entered [redacted] began crying [redacted] was contacted to come and pick the child up. [redacted] On 07/29/19 while [redacted] was babysitting, [redacted] called [redacted] home from work and the child was taken to [redacted]

[redacted]

[redacted]

The Agency reached out to the coroner's office to obtain a copy of the report and was advised a final determination would not be available for several months. Law enforcement advised that the coroner's office did not have a preliminary cause of death and the bruising was consistent with "rough housing," [redacted] It was also suspected that some bruising could have occurred when [redacted] The Agency reached out to the [redacted] to request a review of the photographs and medical records in effort to ascertain if injuries would have contributed to the cause of the child's death. [redacted] would need to see the autopsy before issuing a professional medical opinion. Speculative statements were made regarding potential natural causes, but no formal medical documentation was available to certify a medical diagnosis.

[redacted] was incarcerated due to unrelated circumstances and [redacted] was not allowed to babysit the child upon [redacted] release.

[redacted]

The report centering around the fatality of the victim child was made [redacted] on 09/27/2019. The autopsy has not been received at the writing of this report; however, law enforcement advised the child was found to have a previously undetected medical condition that caused the child's death.

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;
  - [redacted] already has services in place for the family and there is a good support system, which allowed [redacted] during the investigation.
  - Appropriate medical care and childcare were utilized by [redacted]
  - There was positive communication with law enforcement and all involved were cooperative with the process.
  - The positive communication and collaboration among the county systems serves to work for the betterment of the families involved and ensures investigations are conducted within a timely manner.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  - None identified.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  - There are no recommendations to change the current review process.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  - None identified.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  - None identified.

Department Review of County Internal Report:

LCCYS held an Act 33 meeting on 08/27/2019 where medical information and case information was presented. The County report was received by the Region and the CROCYF notified the Administrator, via letter, that the report was reviewed, and the regional office accepted the report of the Act 33 review team.

Department of Human Services Findings:

- County Strengths:
  - The county worked collaboratively with law enforcement and medical providers to conduct a complete investigation. The county continued to reach out to expert medical personal to provide in site into the unexplained bruising of the victim child and her half-sibling.
  - [redacted] while ensuring safety through adequate supervision while the allegations were being investigated.
  - The Agency put intensive family services in place to build parental skills and further monitor [redacted] to assess long term capacities.

- County Weaknesses: and
  - None noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
  - None noted.

Department of Human Services Recommendations:

The Department had no further recommendations.