pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF

Reyna Hubert

Date of Birth: 11/11/2014
Date of Death: 01/02/2015
Date of Oral Report: 01/02/2015
CWIS Referral ID: [redacted]

FAMILY KNOWN TO:

York County Office of Children, Youth and Families

REPORT FINALIZED ON:

11/13/15

Department of Human Services/ Office of Children, Youth and Families, Central Region
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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. York County convened a review team in accordance with Act 33 of 2008.

Family Constellation:

Name:	Relationship:	Date of Birth:
Hubert, Reyna	Victim Child	11/11/2015
[redacted]	Mother	[redacted]1979
*[redacted]	Father	1970
[redacted]	Half Sibling	[redacted]2006

* 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.

Notification of Child Near Fatality:

York County Office of Children, Youth and Families (CYF) was contacted [redacted] regarding the victim child around 4:00pm on January 2, 2015. The police were called to the home and found the child non-responsive on the morning of January 2, 2015. The police suspected that the mother was impaired and had possibly rolled-over on the child while sleeping. The child was deceased. The agency did not receive the referral until after the mother was already home from the hospital.

Summary of DHS Child Near Fatality Review Activities:

The Central Region Office of Children, Youth, and Families obtained and reviewed all current and past case records pertaining to the victim child and her family. Conversations were conducted with the Caseworker [redacted] Supervisor [redacted], and Agency Quality Manager [redacted] throughout involvement but specifically on January 5, 2015, January 13, 2015, and March 5, 2015. The agency conducted an Act 33 meeting on January 22, 2015 and a follow-up meeting on April 7, 2015.

Children and Youth Involvement prior to Incident:

The agency received a [redacted] referral on 9/13/13 regarding the half sibling who was stating that he did not feel safe at his mother's home because he witnessed domestic violence between her and her paramour. He also stated that they have both hit him with a wooden spatula. [redacted] The agency did speak with [redacted] working with the child about monitoring his case and making any future reports if he would express more concern. The agency completed an assessment, [redacted], and closed out on 10/22/13.

The agency then received a report on 9/23/14 stating that the mother was drinking and smoking while pregnant. There were also truancy concerns for the half sibling. The agency opened the case for assessment and followed through with the mother until the birth of her daughter on 11/11/14. The case was closed with no additional concerns and the mother declined agency services. The mother did not appear intoxicated, nor did the hospital have any concerns with the mother or child after the child was born. They reported that the child had [redacted] and there were no concerning substances noted in the labs of mother or child. The mother was following through with [redacted] The truancy issues had also been addressed and the mother was making a concerted effort to provide documentation to the school to justify the tardies and absences.

Circumstances of Child Near Fatality and Related Case Activity:

The York City Police were called to the home after the child was found to be unresponsive. The mother admits to co-sleeping with the child, but the police officer also smelled alcohol on her breath. According to police, the mother has problems with alcohol. It was believed that the mother was impaired at the time of the child's death. However, the police did not complete a breathalyzer test on the mother. The coroner was called to the home and declared the child deceased. This report was registered as a fatality. An autopsy was completed January 5, 2015, with results to be shared at a later time.

The caseworker met with the mother, who had gone to the father's home, [redacted] who stated that she woke up and found the child unresponsive and attempted to do cardiopulmonary resuscitation (CPR). She then called the police. The father came out of the home at this time and began to be very upset at the mother for potentially harming their child. The police were called, but had not responded at that time. The mother left the area after this discussion. Father stated he had seen the child the day prior to the victim child's death and everything was fine. He did explain that the night before he feared the mother was intoxicated and she wasn't answering her phone. He had gone to her home and heard a baby crying so he called police. The police came but did not find the mother intoxicated and would not release the children to the father.

The mother explained that she always becomes somber around New Year's because her brother died on New Year's Day in 2012. After the police had been at her home, family members had stopped in and reported seeing the baby with no concerns. The mother stated that she drank one beer during these visits. She reports that she put the baby to sleep in the Mother's bed at approximately 2:00 AM, and lay down in the bed at 3:00 AM. She then woke up at 8:30 AM and found the child unresponsive. When police came to the home, they reported that the mother smelled like alcohol. She then reported she had 3 beers between 1:00 AM and 2:00 AM.

The half sibling of the child went to stay with a former paramour, who is the child's legal father, during the course of the investigation. He had already been spending a lot of time with this family as they were a support to him and his mother. This family also agreed to allow the father of the victim child to stay with them after the victim child's death as he was very upset and should not be alone at this time. The half-sibling had been with this family on the night that the victim child passed away.

[redacted]

Throughout the investigation, the mother denied heavy drinking. As there was no test done at the time of incident, there was no way to determine if she had been intoxicated when the victim child was with her in the bed. An autopsy later revealed a skull fracture traveling down the middle of the skull, but the mother could not explain this, beyond saying that the victim child had fallen off of the bed a few weeks earlier. It would not have been seen on a skeletal survey if there was no bone displacement. The victim child had been seen at the hospital on December 30, 2015 for [redacted]. According to the report, the skull fracture would fit this time frame, but was not the cause of death.
[redacted]

The autopsy results were received on March 6, 2015, with a cause of death listed as UNDETERMINED.

Current Case Status:

The family was accepted for ongoing services with the half-sibling remaining with his legal father [redacted] The mother is working with [redacted] to focus on appropriate parenting [redacted] The agency reports that the mother has maintained appropriate housing and income and has attended all appointments. The agency continues to monitor her progress and completion of the Family Service Plan goals. There have been no continued concerns with drugs or alcohol.

The agency is working with the legal father [redacted] for the half- sibling. Thus far the father has been resistant to this service, but the agency continues to have this discussion at visits with the father.

[redacted] No charges have been filed as of this point. [redacted]

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

A Fatality/Near Fatality Multidisciplinary Team (MDT) Act 33 meeting was held on January 22, 2015 at the York Hospital Pediatric Unit. The team was comprised of local CYS professionals, medical professionals, law enforcement, and regional staff. A follow-up meeting was held on April 7, 2015, after the autopsy report had been finalized.

- Strengths:
  - The MDT worked together well to complete the investigation and share information.
  - The family has a lot of supports that called the police for welfare checks. Family has also stepped in to care for the half-sibling.

- Deficiencies:
  - There was a concern with the final autopsy report as it stated that the victim child was dehydrated due to a sunken area in her head. However, the report then stated that she was not dehydrated.
  - It was determined that the victim child had a skull fracture at the time of death, but that it was most likely not related to the death. However, the victim child was seen on 12/30/14 and may have had this injury at that point, and not necessarily would have been found by the hospital. More follow up is needed with the mother to understand the cause of this injury.

- Recommendations for Change at the Local Level:
  - There was discussion that CYS has access to instant alcohol screens. Local law enforcement were not aware of this, and one was not conducted in this case due to the amount of time before CYS was notified of the fatality. Law enforcement could use this tool in the future.
  - CYS also recommended that law enforcement contact them at the time of the incident so that they can adequately assess the situation in conjunction with law enforcement.

- Recommendations for Change at the State Level:
  None noted.

Department Review of County Internal Report:

York County CYS provided a report on the Near Fatality of the victim child to the Regional Office on April 17, 2015. The report contained all required information and a summary of the findings of the agency Act 33 review team meeting. Verbal approval of the report was provided to the agency on the date of receipt. Written approval was sent to the agency on April 23, 2015.

Department of Human Services Findings:

- County Strengths:
  - The agency was able to offer a lot of insight into the case and share information with law enforcement that will aid them in future investigations.
  - The agency was able to identify the steps that should and could have been taken in this case if they had been notified sooner of the incident, and able to convey the urgency of this information to all parties involved.

- County Weaknesses:
  - None Noted.

- Statutory and Regulatory Areas of Non-Compliance:
  - None Noted.

Department of Human Services Recommendations:

The agency should reach out to local law enforcement agencies to inform them of certain services that the agency can provide in investigations, such as instant drug screens.

The agency should also continue to strengthen their MDIT Team, contacts, and supports, to assure that they are alerted of child welfare related incidents in a timely manner. In this case the agency had to do some follow-up work because they were not immediately alerted to this situation. This was at no fault of the agency, but could have been prevented if law enforcement had contacted the agency more expeditiously.