



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Alivia Del Rio

Date of Birth: 11/17/13

Date of Death: 12/27/14

Date of Report to ChildLine: 12/28/14

FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Schuylkill County CYS

REPORT FINALIZED ON:

June 23, 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. Section 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, 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.

Act 33 of 2008 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. Schuylkill County CYF has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 1/23/15.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth (month/date/year):</u>
Alivia Del Rio	Child Victim (CV)	11/17/2013
[REDACTED]	Sibling	[REDACTED] 2012
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Mother	[REDACTED] 1988
[REDACTED]	Mother's Paramour	[REDACTED] 1985
[REDACTED]	Father	[REDACTED] 1988

* 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 Northeast Office of Children, Youth and Families (NERO) obtained and reviewed all current and past case records pertaining to the [REDACTED] Family. NERO also participated in the Act 33 meeting held on 8/28/2014. A pediatrician and all CYF staff who had been involved in the case were present. The District Attorney (DA) and law enforcement involved in this case were invited, but did not attend. The police felt that sharing information [REDACTED] would not be advisable. They were informed of the confidentiality waiver signed by members, but opted not to attend the meeting despite this.

Children and Youth Involvement prior to Incident:

On 5/28/13 Schuylkill County CYS agency received a referral regarding the victim child's oldest sibling being found outside the home unsupervised. When police returned child to family home, child's father was present with child's other sibling and the father reported he thought the child had gone to the store with his mother. The father said there was a miscommunication between the parents. Agency staff made contact with mother and the children, following the referral, at which time it was learned father was excluded from the home earlier that day due to a recent domestic violence incident. Mother understood concerns for appropriate supervision and family was closed at intake on 6/24/13.

On 11/26/14 Schuylkill County CYS agency received a referral regarding the victim child's oldest sibling causing injuries to the victim child and her two year old sibling. The victim child and the two year old sibling had been coming to daycare over the last two weeks with bumps, bruises and scratches which were determined to be the result of aggression from victim child's oldest sibling. On 11/26/14 the victim child's two year old sibling was examined at the pediatrician's office where a full skeletal x ray was ordered due to significant bruises. [REDACTED]

[REDACTED] was to be made by the pediatrician. The case was assigned 11/26/14 to a [REDACTED] caseworker. The assigned caseworker made an unannounced home visit on 12/3/14. No one was present so the caseworker left a card. The assigned caseworker called the home on 12/3/14 and left a message to contact the agency. The assigned caseworker then sent an appointment letter to family for appointment 12/23/14 at 3:30pm. The mother contacted CYS office and cancelled the scheduled home visit the day of appointment. The case remained pending on intake status at the time of the victim child's death.

Circumstances of Child Fatality and Related Case Activity:

On 12/28/14 the agency worker responded to the family home and met the victim child's mother, her two siblings, paramour to the victim child's mother, paramour's sister and the paramour's sister's boyfriend. Also present in the home were local police and a county detective who were waiting for state police [REDACTED]

[REDACTED] reported to the agency worker that a call came in at 22:11 hours on 12/27/14 for a one year old with difficulty breathing. CPR was performed in the home but the victim child was pronounced dead [REDACTED] reported they were informed the victim child was struck in the head with a Fisher Price plastic toy giraffe. The victim child evidenced a contusion to the right side of her head from the alleged assault by the toy giraffe and bruises to her inner arms, inner thighs, lower back and scabs on her hairline.

The victim child's [REDACTED] reported she went to work around 11 am on 12/27/14, leaving the mother's paramour home with the three children. The

mother's paramour reported he put the children to bed around 7pm and approximately 30 minutes later he heard the victim child upstairs crying. The mother's paramour stated he went upstairs to see why the victim child was crying and saw the victim child's five year old sibling standing on the outside of the victim child's crib; the sibling was reaching over the crib with a toy giraffe. The mother's paramour reported he saw the victim child's sibling hit the victim child in the head. The mother's paramour reported he brought the victim child and sibling downstairs and checked the victim child who evidenced a "goonie" on the right side of her head. The victim child appeared ok and was laughing so paramour reported he returned the victim child and sibling to bed. The victim child's mother returned home from work around 8pm. When the victim child's mother and paramour went upstairs to go to bed around 10pm, the mother's paramour checked on the victim child and found her face down in her crib, cold to touch.

[REDACTED]

CYS informed the mother that the victim child's death [REDACTED]

[REDACTED]

The sister to the mother's paramour stayed at the family home with the two year old sibling while the mother and her [REDACTED]

[REDACTED]

The mother discussed [REDACTED]

[REDACTED]

A discussion was held with the [REDACTED]

The paramour does not live in home with the mother and children. He resides down the street. He has a teenage daughter from another marriage who visits frequently.

On 12/28/14 a [REDACTED] of the victim child revealed [REDACTED] but no skull fractures. On 12/29/14 a full forensic autopsy was completed at Lehigh Valley Hospital.

The [REDACTED] worker met with the [REDACTED]

[REDACTED]

[REDACTED] The caseworker made contact with the victim child's mother and paramour on 12/30/14 [REDACTED]

[REDACTED] met to discuss the autopsy results with the forensic pathologist on 5/4/15. The results were as follows: Forensic reports show the VC sustained Bi-Lateral Sub-Dural Hemorrhages, Retinal Hemorrhaging in both eyes, Optic Nerve Sheath Hemorrhaging in both eyes, and Sub-Arachnoid Hemorrhaging. Reports reflect these injuries could not have been sustained as part of a normal childhood accident. The cause of death has been listed as Blunt Force Trauma and the Manner of Death ruled HOMICIDE.

On 5/22/15, the paramour was arrested for Murder of the 3rd degree, Aggravated Assault, Involuntary Manslaughter, Endangering the Welfare of Children, Simple Assault, Recklessly Endangering Another Person, and False Report-Falsely Incriminating Another.

Due to conflicts between the injuries sustained by the VC, the Mechanism of injury as described by [REDACTED], the forensic reports showing the manner of death to be homicide, [REDACTED]

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:

- Team members identified the pending police investigation as strength.
- Additionally, the mother was commended for reaching out for help at the pediatrician's office and the pediatrician was commended for contacting the agency to try and assist the mother in securing [REDACTED] until their referrals could be made.

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

- The team identified the lack of cooperation in conducting a joint investigation as a deficit. Team members acknowledged confidentiality in criminal investigations surrounding the death of a child, however, indicated Children and Youth Services is compelled as an agency by confidentiality also. The County has an active MDIT team, however it is only successful when law

enforcement involved in the case participates. Participation is sporadic depending on the jurisdiction.

- A discussion was held regarding the pending intake, the lack of contact made with the family, the mother's lack of response to CYS attempts to engage her for [REDACTED] and whether or not it is felt mother will continue to not allow paramour unsupervised with her children.

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

- Recommendations were made for Children and Youth to make additional attempts in initiating contact with family members when referrals are received.
- The team also made suggestions for the two year old sibling to possibly have a forensic interview to see if she can provide any information surrounding victim child's death.

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

- none

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

- The Act 33 team talked about attempting to better educate law enforcement on the County Child Protective Service (CPS) practices and procedures so that that law enforcement would be more likely to collaborate with CYS in investigations.

Department Review of County Internal Report:

NERO received the Schuylkill County Child Fatality Report on 5/01/15. DHS finds the county's internal report to be an accurate representation of the discussion at the Act 33 meeting. The County was sent a letter acknowledging receipt of the report.

Department of Human Services Findings:

- County Strengths: The agency did respond immediately to the report from the police on December 28, 2014. They also reported the fatality to ChildLine immediately. The agency also made attempts to conduct a joint investigation. The caseworker shared all information received with the police and invited law enforcement and the District Attorney to the Act 33 meeting.

- County Weaknesses: While the agency responded immediately to the report from the police, there was an obvious delay in seeing this child when the initial referral was received in November. There was no justifiable explanation for not attempting visits sooner. This was recognized and discussed at length at the Act 33 Meeting. It is difficult to determine if the outcome might be different if children and youth had been able to assess the family sooner. The agency did state at the Act 33 meeting that they were looking at policies and procedures to ensure that this did not occur again. There is also a concern in this case that law enforcement is not open to sharing information with the agency. The agency continues to make efforts to engage the state police.
- Statutory and Regulatory Areas of Non-Compliance by the County Agency. – The agency will be cited under chapter 3490.232(c) for not meeting the appropriate response time. The case was assigned on 11-26-14. The response time for this case was 7 to 10 days. No contact was made with the family until after the child's death on 12-28-14. One attempt to see the family was made on 12-3-14. A letter was sent to the family with an announced contact date for 12-23-14 which the mother cancelled. There is no justification documented as to why no attempts to see the family were made from December 3rd to December 23rd.

Department of Human Services Recommendations:

- DHS is recommending a thorough review of the policies and procedures regarding response times in Schuylkill County.
- DHS is also recommending that the County continues to try to reach out to the District Attorney and Law enforcement to educate them on the benefits of joint investigations as well as the sharing of information.