



REPORT ON THE FATALITY:

Elena Moran-O'Brien

Date of Birth: 08/13/2014

Date of Death: 01/05/2015

Date of Report to Child Line: 01/06/2015

CWIS Referral ID: [REDACTED]

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

Montgomery County Office of Children and Youth

REPORT FINALIZED ON:

02/26/2016

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.

Montgomery County Office of Children and Youth (MCOCY) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 02/02/2015.

Family Constellation:

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Elena Moran-O'Brien	Victim Child	08/13/2014
[REDACTED]	Biological Mother	[REDACTED] 1986
[REDACTED]	Biological Father	[REDACTED] 1985
* [REDACTED]	Day care worker	[REDACTED] 1987
* [REDACTED]	Day care worker	[REDACTED] 1981

* 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 (SERO) obtained and reviewed all current case records pertaining to this family. SERO staff participated in the ACT 33 meeting that occurred on 02/04/2015 in which medical professionals and law enforcement were present and provided information regarding the incident.

Children and Youth Involvement prior to Incident:

There were no prior reports for this family with Montgomery County

Circumstances of Child (Near) Fatality and Related Case Activity:

On 01/05/2015, at 10:51am, the child was found unresponsive in a crib by staff employed with the [REDACTED] Learning Center. The child was transported to the Chestnut Hill Hospital by ambulance and pronounced dead at 11:40am.

Pennsylvania Department of Human Services, Office of Child Development and Early Learning (OCDEL) initially received a complaint on 01/05/2015 and conducted an unannounced monitoring of the learning center on the same day. A review of the learning center's on-site video footage revealed the child sitting in a swing and a staff person standing behind the child and placing a sheet over the child's head. The footage further revealed the same staff person roughly lifting the child out of the swing without unfastening the swings safety straps and walking out of the view of the camera with the child's head still covered by the sheet. Based on the video footage it could not be determined if the child was responsive at that time.

On 01/06/2015, MCOCY received a report regarding the child's death and the case was assigned to an investigator. [REDACTED]

On 01/06/2015, [REDACTED] interviewed one of the child care workers who was working in the area and with the child on 01/05/2015 in order to determine the events leading up to the child's death. [REDACTED] who is named as an alleged perpetrator informed the detective that she was assisting [REDACTED] in the infant care room on the date of the child's death. After informing [REDACTED] of the events of the child's arrival to the learning center, [REDACTED] informed [REDACTED] that she was responsible for the other infants in the room however she periodically assisted [REDACTED] to soothe and or monitor the child. [REDACTED] further reported that the child was at times fussy that morning therefore she assisted [REDACTED] to feed the infant as well as rock her when requested. [REDACTED] also reported that at some point in the morning she did place the child in the swing in order to quiet her down but denied placing the sheet over the child's face. [REDACTED] further reported that the victim child did have a sheet placed around her face by [REDACTED], but was informed that this was something that was done with this child in order to keep her pacifier in place. [REDACTED] denied causing harm to the child or witnessing harm being done to the child by [REDACTED].

On 01/07/2015, [REDACTED] met with [REDACTED] who was also responsible for the child's care on 01/05/2015. [REDACTED] who is also named as another alleged perpetrator, informed [REDACTED] that the child was one of the first children to arrive at the learning center at 8am on the morning of 01/05/2015. [REDACTED] further reported that the learning center was just opening back up after being closed in observance of the Christmas and New Year's holiday and both of the child's parents accompanied the child to the day care center to drop her off. Neither parent indicated any medical concerns or changes with the child prior to leaving the child. [REDACTED] further reported that the child was cared for by her and [REDACTED] on the morning of the child's death. [REDACTED] reported that the child was a little fussy upon being woken up by another child's crying, so she transferred the child from her car seat to a bouncing seat in front of her on the floor and monitored her for approximately ten minutes. When the child was still fussy, [REDACTED] reported that she placed the

infant in a crib on her stomach with a pacifier in her mouth and left the child to go to the bathroom. Upon her return, she noticed that the other children that had arrived were crying, as well as the child whom [REDACTED] had removed from the crib. [REDACTED] reported that she began to make bottles for the children and upon returning she took the child from [REDACTED] and changed her diaper before handing the infant back to [REDACTED] to be fed.

[REDACTED] went on to report that [REDACTED] mentioned that the child did not want the bottle and was still fussy so she placed her in the swing in attempts to comfort her. [REDACTED] went on to mention that the child was in the swing and she believed it was cold therefore; she placed a blanket up to the child's chest area and allowed the child to drift off to sleep. [REDACTED] further report that the child remained in the swing for 20 minutes and was removed from the swing by her and placed into her crib on her stomach with her pacifier. Fifteen minutes later, [REDACTED] went to check on the child and did not see any respiration and upon picking her up she noticed blood was coming from the infant's nose. [REDACTED] reported that she ran with the child to the main office and was assisted by another co-worker to perform CPR on the infant until the ambulance arrived.

On 01/14/2015, [REDACTED] MCOCY investigator interviewed the child's parents and was informed that there was nothing abnormal about the day or days leading up to the child's death and denied the child having any falls, injuries or accidents that could have led to the child death.

On 01/15/2015, [REDACTED] MCOCY investigator met with the [REDACTED] Learning Center's Director and conducted an interview surrounding the employees that work within the facility, training that staff received and regulatory statutes and practice standards. The Director informed the investigators that the facility had remained closed since the incident.

On 02/27/2015, The Philadelphia Medical Examiner's office determined that the child died of natural causes, (SIDS). The final status was submitted on 03/12/2015. The [REDACTED] report was [REDACTED] for both alleged perpetrators [REDACTED]. Law enforcement determined that no criminal charges would be filed.

As a result of the unannounced monitoring conducted by OCDEL on 01/05/2015, the [REDACTED] Learning Center certificate of compliance was removed due to multiple violations and permanently closed.

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 county conducted their investigation collaboratively with all Multi-Disciplinary Team Members.
- Deficiencies in compliance with statutes, regulations and services to children and families;

None

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

None

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
 - OCDEL statutes and regulations to change to mandate surveillance video in all child care facilities with the exception of the bathroom. In addition, OCDEL to discontinue the practice of offering free applications to applicants who wish to operate day care facilities.
 - OCDEL to initiate a public campaign of licensing summaries so that parents and caregivers are aware of facility strengths and challenges.
- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
 - The Department of Human Services should institute online training for all employees to include regulatory mandates. In addition, the department to assure funding allocation for routine unannounced monitoring visits.
 - In order to obtain comprehensive recommendations, the ACT 33 timelines should be adjusted to allow for all investigations to be completed prior to the review.

Department Review of County Internal Report:

SERO received the MCOCY Child Fatality Team draft and concurred with all of the information in the report. The final draft was received on 05/11/2015.

Department of Human Services Findings:

- County Strengths:
 - MCOCY responded to this referral in a timely manner and conducted a thorough assessment.
 - The county worked cooperatively and collaboratively with all Multi-Disciplinary Team members.

- County Weaknesses:
 - There were no county weaknesses noted.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.
 - MCOCY was found to have operated within statutory and regulatory compliance with regards to this incident

Department of Human Services Recommendations:

Specific training should be mandated by OCDEL to include educational videos with test for all child care providers caring for children in the 0-15 month age range on Sudden Infant Death (SIDS).