COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE DEATH OF

SELENA ORTIZ

BORN: 8/11/09
DIED: 10/14/09

REPORT DATED 3/4/10

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. 6349 (b))

Reason for Review.

Senate Bill No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and became effective December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatalities and near child fatalities as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

Household Members

Name	Relationship	Date of Birth
Selena Ortiz	Victim Child	08/11/2009
[redacted]	Mother	[redacted]1978
[redacted]	Father	[redacted]1968
[redacted]	Brother	[redacted]/2007

Non Household Members

[redacted]	Cousin	Adult

Notification of Fatality / Near Fatality:

On October 9, 2009 the Department of Human Services (DHS) received a [redacted] report alleging lack of supervision which resulted in a medical condition. The 2 year old climbed up on the victim child's porta-crib, causing the porta-crib to tip over. The victim child fell out of the porta-crib and hit her head on a rocking chair. The victim child was not breathing and was unresponsive. The father was home and called the EMS. The extent of the injuries was unknown at the time the [redacted] report was made, but St Christopher's Hospital classified victim child as a near fatality.

On October 9, 2009 DHS received a supplemental report that was called in by the [redacted] The victim child was brought in by EMS in full cardiac arrest and unresponsive. The father stated the victim child's brother knocked the porta-crib over, causing the child to fall out and hit her head on a rocking chair. Victim child has a palpable [redacted] on left side of her head and [redacted] on the right side of her neck. Father was home with the children when the incident happened. The reporting source couldn't say whether or not the father's report matched the child's injuries. The child was intubated and [redacted] in the [redacted]. The child was not expected to survive.

Documents Reviewed and Individuals Interviewed:

The Department of Human Services (DHS) provided the case file. The Regional Office reviewed the case file and interviewed the DHS Social Worker that worked with the family and is still employed at DHS. The Regional Office attended the Act 33 Fatality Review held on November 6, 2009.

Previous CYS Involvement:

This family was not known to DHS prior to this fatality.

Circumstances of Child's Fatality or Near Fatality:

On October 9, 2009 DHS made a visit to St. Christopher's Hospital for Children to assess the safety of the victim child. The medical team reported the victim child may not survive the night. The victim child had a [redacted] and [redacted] The parents, Mr. and Ms. [redacted], were interviewed by DHS and the Special Victims Unit (SVU). The father, [redacted], reported that he and his wife are employed by St. Christopher's Hospital for Children. The father reported he works as a transporter at the hospital. He was at home taking care of his children the victim child and her brother, [redacted] when the incident occurred. The mother, [redacted], was working in the emergency room when the victim child was admitted as a near fatality.

The father stated that it was almost feeding time for the victim child and he went into the kitchen to prepare a bottle. When he went into the kitchen, [redacted] was on the floor watching television. The father stated that when he came out of the kitchen the brother had grabbed the porta-crib. It was leaning and Selena tipped over and rolled off the porta–crib. The father stated he tried to catch her since the brother's rocking chair was on the floor, but she had already fallen. The father stated that his daughter, Selena hit the rocking chair on the side of her head. The father picked the child up and her eyes rolled in the back of her head. The father stated he noticed a black bruise on the side of her head and he began to administer CPR. The father reported he continued CPR until EMS arrived. EMS transported the child to St. Christopher's Hospital for Children. The father's account of the incident was consistent with his report to SVU. According to SVU and DHS the incident appeared to be an accident.

The doctor reported to DHS that they had to be objective because they worked closely with the parents at the hospital. In addition, the father was interviewed by the doctor who determines if the injuries are a result of child abuse.

The son, [redacted], was picked up by a family member, [redacted]. The father reported [redacted] would be staying with the family member while Selena was in the hospital. On October 9, 2009, DHS made a safety visit to the family member's home to ensure the safety of [redacted]. DHS completed a safety plan

with Ms. [redacted] and the parents. [redacted] would remain with Ms. [redacted] until the investigation was completed The parents are allowed to see [redacted] but not allowed to take him home. The intake social worker informed the family that there would been an assigned social worker to conduct an in-home safety assessment to determine the needs of [redacted]

On October 11, 2009, DHS received a telephone call from SVU. According to SVU [redacted] reported the father's explanation was inconsistent with the child's injuries. SVU reported to DHS that they were going to the home with a search warrant to obtain the porta-crib and the rocking chair. [redacted] reported there were too many injuries, such as the amount of swelling on the brain and the bruise on the body, which could not have happened from a short fall. [redacted] requested that [redacted] have a [redacted] for [redacted] The results of [redacted] skeletal were clear.

On October 13, 2009, [redacted] reported Selena had a [redacted]. A [redacted] was conducted and Selena was brain dead; a second test was completed the next day. DHS conducted a second home visit to Ms. [redacted] home to ensure [redacted] safety. In addition, the safety plan was revised. Due to the inconsistencies in the father's explanation of the injuries, the parents were not allowed to visit The mother wasn't allowed visits because she was in agreement with the father's explanation. [redacted] unsupervised and he was to remain living with Ms. [redacted] until the investigation was completed.

On October 14, 2009, the [redacted] reported to DHS that Selena failed her [redacted] "miserably" [redacted]. The doctor reported that Selena had [redacted] and a [redacted] The [redacted] stated that these types of injuries do not occur from a 2ft.fall from a crib or pack and play. The [redacted] stated if the incident happened at approximately 5pm and [redacted] was conducted at 7pm, there was too much swelling on the [redacted] for the time frame. The [redacted] stated if [redacted] occurs it takes several hours for the baby's [redacted] shut down or for the child to be unconscious. A 2ft. fall from a crib/pack and play would not cause enough [redacted] for the child to go unconscious and stop [redacted]. Selena was removed from [redacted] and declared dead on October 14, 2009 at 3:30 pm.
The [redacted] at Children's Hospital confirmed that the [redacted] on the victim child revealed [redacted] of the [redacted] and [redacted] According to the [redacted] these types of [redacted] and [redacted]. The [redacted] were not previously reported to DHS. The [redacted] October 15, 2009, [redacted] were [redacted] report. Selena had [redacted] and [redacted] in both legs. These types of injuries are non accidental and are absolutely [redacted].

Current / most recent status of case

- The investigation revealed that the victim child suffered severe pain and died as a result of brain injuries on October 14, 2009. This case was [redacted] on November 9, 2009.
[redacted] Special Victims Unit filed criminal charges against the father, [redacted]
- DHS reported the father was incarcerated for a brief period. The father was released on bail and the next court hearing is still pending.

Services to children and families:

- On October 19, 2009, an OPC (Order of Protective Custody) court hearing was held for the sibling [redacted]. He was placed in the custody of DHS and living with paternal cousin [redacted]. Ms. [redacted] has temporary legal custody of [redacted]
- Ms. [redacted] escorts [redacted] to day care three times a week.
- According to DHS the father was released from prison. Since his release, DHS referred the mother and the father to ARC. Both parents are required to attend [redacted] and [redacted]. The father attends the father initiative program, the primary focus is anger and domestic abuse.
- The parents have scheduled weekend visits [redacted] at Ms. [redacted] home.
- DHS conducts in home safety assessments with [redacted], twice monthly.

County Strengths and Deficiencies as identified by the County's Near Fatality Report:

Strengths-

- The county immediately provided information to the Regional Office regarding the child and the family. The county forwarded documentation within 48 hours of the oral report. The investigation was thorough and was conducted within the required time frame.

County Recommendations for changes at the Local (County or State) Levels as identified by way of County's Near Fatality Report:

Reducing the likelihood of future fatalities and near fatalities directly related to child abuse and neglect:

- The Act 33 Review Team recommends that the county develop means to collaborate with the medical providers to ensure that relevant information communicated is current and updated as needed. The medical team would benefit from training on the Mandated Reporting Regulations. During the Act 33 meeting the intake social worker reported she was

unable to retrieve current information from the doctors. St Christopher agreed that they would call the hotline immediately when they need to report additional information.

- The Act 33 Review team recommends the county implement training for the medical staff at Saint Christopher's Hospital to understand the necessity for the hospital social workers to be accessible. The county must have immediate access to the child and family to assess safety. The DHS social workers reported during the ACT 33 review, there are occasions when the DHS worker arrives at the hospital, they are not always granted immediate access to the children. They are usually instructed to wait for the hospital social worker. Due to the severity of the cases DHS state there are times when family members may arrive and sabotage the case.

SERO Findings:

Strengths-

- Initially the [redacted] was received as lack of supervision which resulted in [redacted] and determined to be an accident. DHS received additional information and redirected the investigation accordingly.
- The additional in-home safety assessments and collateral contacts were conducted within the required time frame.

Statutory and Regulatory Compliance issues:

- There were no regulatory concerns.