COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

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REPORT ON THE FATALITY OF:

Enzo East

Date of Birth: 3/3/2011
Date of Death: 6/30/2011

FAMILY NOT KNOWN TO ANY PUBLIC OR PRIVATE CHILD WELFARE AGENCY

REPORT FINALIZED ON: 02/24/2012

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 1147, Printer's Number 2159 was signed into law on July 3, 2008 by Governor Edward G. Rendell. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW 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. Montgomery County convened a review team in accordance with Act 33 of 2008 related to this report on 7/25/2011.

Family Constellation:

Household members:

Name:	Relationship:	Date of Birth:
Enzo East	victim child	3/3/2011
[redacted]	mother	[redacted]1992

Non-Household members

Name:	Relationship:	Date of Birth:
[redacted]*	paternal great grandmother	[redacted]/1941
[redacted]*	paternal great grandfather	[redacted]/1945
[redacted]*	father	[redacted]/1986

*in one household

Notification of Child Fatality:

On 6/25/2011, Montgomery County received a report concerning three month old Enzo East. The mother had presented at CHOP with Enzo, reporting that she had left him in the care of his father from 6/18/200 to 6/20/2011 while she went to the shore. She noticed when she picked him up on the 20th that he appeared drowsy and was not eating. The mother called the doctor. Enzo was seen at Lansdale Hospital on 6/21/2011 and by the pediatrician on 6/22/2011. He was diagnosed as having [redacted] and virus (respiratory).When he began [redacted] on 6/23/2011, the mother took him to the ER at Abington Hospital. He was given fluids, and discharged several hours later.

On 6/24/2011, the baby was in the father's care. The father reported that he was fine in the morning, but became fussy in the afternoon. The baby vomited and the father gave him a bath. The baby turned blue and stopped breathing. The baby was transported to Lansdale Hospital and Medevaced to CHOP. The parents denied any trauma. The father did report that about a month previously,

Enzo had scooted off the couch and hit his head. CHOP reported that Enzo had possible bleeding in the eye, subdural hemorrhage, swelling around the skull and skull fracture. Enzo was initially placed on [redacted] but subsequently died on 6/30/2011.

Summary of DPW Child Fatality Review Activities:
The Southeast Region Office of Children, Youth and Families obtained and reviewed current case records pertaining to this family. Follow up interviews were conducted with [redacted], Montgomery County QA. The regional office also participated in the County Internal Fatality Review Team meeting on 7/25/2011.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:
No prior involvement with child welfare agencies.

Circumstances of Child Fatality and Related Case Activity:

- On 6/25/2011, the father was interviewed by Montgomery County Detective [redacted] and Towamencin Township Police [redacted]. The father reported that he gave Enzo a bottle, and he vomited. The father gave him a bath, then attempted to give him another bottle. Before Enzo was given the second bottle, he vomited "green". The father initially reported that he had attempted CPR after Enzo had stopped breathing. The father reported that he had dropped him during the CPR. The back of his head struck the wall with force as he fell.
- The police confronted the father with inconsistencies in his account. The father provided another account. He reported that Enzo had vomited into his (the father's) shorts. He carried Enzo into the bathroom to bathe him. He reported that he was feeling "overwhelmed", and struck Enzo's head hard against the sink. He told police that he heard a "loud bang" when Enzo's head struck the counter below the mirror. Enzo was described by the father as being "in shock". The father bathed Enzo and noticed that he was not breathing, and that Enzo's eyes were rolling back into his head.
- Enzo died on 6/30/2011. Autopsy indicated that he died as a result of blunt force trauma. The manner of death was determined to be homicide. The father confessed to harming the child and was arrested on 6/25/2011.
- Case was [redacted] against the father on July 16. 2011. Family was [redacted] as there were no other children in either parent's household.

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

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. Montgomery County has convened a review team in accordance with Act 33 of 2008 on 7/25/2011.

Strengths:

None identified

Deficiencies:

None identified

Recommendations for Change at the Local Level:

- Ongoing parenting information is needed for new fathers. This information should be available in places where fathers are likely to be, such as social networking sites. This information should include shaken baby syndrome.
- The director of Montgomery County OCY will contact the Montgomery County Health Department to request that information about shaken baby syndrome be added to the Facebook page of the Montgomery County Health Department.
- OBGYN's, physicians, pediatricians and other medical personnel should increase the education given at the child's birth. A suggestion was made that bibs be given to new parents that provide information about websites with information about parenting newborns and infants, and shaken baby syndrome in specific.

Recommendations for Change at the State Level:

- None identified

Department Review of County Internal Report:

The Department has received and reviewed the report provided by the county. Recommendations were made about the need to educate the public about shaken baby syndrome, and the role of other agencies or professionals. The County should collaborate with other professionals in the community who are serving families with infants and explore methods to educate young parents, especially utilizing methods such as social networking sites

Department of Public Welfare Findings:

County Strengths:

- The County collaborated with the local police departments.

County Weaknesses:

- The County's written review did not include many details about the [redacted] criminal investigation process at the request of the District Attorney's office due to pending criminal court action.

Statutory and Regulatory Areas of Non-Compliance:

- None identified

Department of Public Welfare Recommendations:

Our society has become more focused on technology and communication through various social networking sites. The County and State agencies must adapt our community educational efforts as our society changes.