



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY of:

Miila Remi-Gia Colon

Date of Birth: 8/15/2012

Date of Death: 11/8/2012

FAMILY KNOWN to:

Luzerne County Children and Youth

REPORT FINALIZED ON: 6/3/2013

Date of Oral Report: 11/8/2012

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. 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. Luzerne County convened a review team on December 5, 2012 in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Miila Remmi-Gia Colon	Victim Child	8/15/12
[REDACTED]	Sibling	[REDACTED]/09
[REDACTED]	Sibling	[REDACTED]/10
[REDACTED]	Sibling	[REDACTED]/05
[REDACTED]	Sibling	[REDACTED]/04
[REDACTED]	Sibling	[REDACTED]/02
[REDACTED]	Mother	[REDACTED]/83
[REDACTED]	Father of [REDACTED]	[REDACTED]/84
[REDACTED] *	Father of [REDACTED]	[REDACTED]/82
[REDACTED] *	Maternal Grandmother	[REDACTED]/55
[REDACTED] *	Maternal Grandfather	Unknown
[REDACTED] *	Maternal Aunt	[REDACTED]/85

*Non-Household Members

Notification of Child Fatality:

On November 8, 2012, Luzerne County Children and Youth received a [REDACTED] report alleging [REDACTED] of Miila. Miila was pronounced dead at Hazleton General Hospital. At the time the report was received by the agency, the cause of death was unknown. The family reported that the child's 3 year old sibling was found in the pack-n-play with the child that morning and that the father had found the 3 year old sibling in the child's pack-n-play previously. The family home had two bedrooms of which the parents slept in one room and all 6 of the children slept in the other room. An autopsy was performed on November 9, 2012. [REDACTED]

[REDACTED]. The cause of death was determined to be asphyxiation due to co-sleeping with a sibling.

Summary of DPW Child Fatality Review Activities:

The Northeast Regional Office of Children, Youth and Families received and reviewed all records from Luzerne County Children, Youth and Families pertaining to the [REDACTED] family. The case was also discussed with the [REDACTED] Supervisor and Manager. The Regional Office was also present at the County Act 33 Review meeting held on December 5, 2012.

Summary of Services to the Family:

Children and Youth involvement prior to Incident:

The agency was involved with the family at the intake level on two occasions. On July 22, 2009, a [REDACTED] referral was received alleging lack of supervision and drug use. The allegations were unsubstantiated and the case was closed. On February 16, 2012, a [REDACTED] referral was received alleging poor hygiene of the children and also a lack of cooperation by the parents with the school. At the time of the referral, one of the children told the caseworker that his mother was pregnant; however, mother told the caseworker she was told she was unable to have more children. The referral issues were addressed with the family and the case was closed at the intake level.

Circumstances of Child's Fatality and Related Case Activity:

The report was received by the agency in the afternoon on November 8, 2012. Miila was pronounced dead that morning at Hazleton General Hospital. The cause of death was unknown at that time. The parents reported that the child was sleeping in her pack-n-play in the same area as her five siblings while her parents slept in a separate room. The child's 3 year old sibling was found in the infant's pack-n-play when the mother found the child unresponsive. The natural father and siblings confirmed that the child had crawled into the infant's pack-n-play on multiple occasions in the past. An autopsy was performed on November 9, 2012. [REDACTED]

[REDACTED] The cause of death was determined to be asphyxiation due to co-sleeping with sibling.

During the course of the [REDACTED], through the review of medical records, it was learned that the child was [REDACTED]. Two medical appointments were missed when the child was to be checked and weighed. The child was then brought to the hospital and was [REDACTED] on September 27, 2012 [REDACTED]. The medical records confirm that the mother admitted that she was not following the infant's feeding schedule as directed and that the mother would allow the child to sleep through the feedings. It was also reported that the mother had sporadic contact with the infant while she was [REDACTED]. The child was [REDACTED] to the mother and was then seen again on October 9, 2012 for a follow-up appointment and had gained one pound. There was no referral made to the county agency regarding the child's [REDACTED]. The agency was unaware of the child's [REDACTED] prior to the receipt of the report on November 8, 2012 regarding the child's death.

Upon receipt of the referral, the agency completed a preliminary safety assessment for the five sibling children. It was determined that the children were not safe in the care of the parents because the parents failed to supervise the children or take the necessary safety precautions as to prevent the 3 year old child from continuing to crawl into the infant sibling's pack-n-play. A safety plan was developed that required the maternal grandparents and the maternal aunt to care for the children and supervise their contact with their parents.

The [REDACTED] was completed by the county agency on December 4, 2012. Both parents were [REDACTED] lack of supervision resulting in the child's death. At the conclusion of the agency's assessment, the family was opened for services and the agency [REDACTED].

Current Case Status:

At the conclusion of the [REDACTED], the children remained with the maternal grandparents under the safety plan. Unfortunately, the maternal grandfather suffered a heart attack in December, 2012 and passed away. [REDACTED]

[REDACTED]; however, the family was in agreement with temporary custody of [REDACTED] remaining with the maternal grandmother who would reside with the three children and the natural mother in the mother's home. The family also agreed that custody of [REDACTED] would be with the maternal aunt and she and the natural father would reside with the children at the maternal grandmother's apartment. The family had liberal visitation supervised by either the maternal grandmother or maternal aunt. [REDACTED]

[REDACTED] Most recently, the maternal grandmother reported to the agency that she has located a residence in Wilkes-Barre that will accommodate the whole family. Their anticipated move date was April, 28, 2013. The next court review date is May 10, 2013 at which time the appropriateness of unsupervised visitation will be addressed.

To date, both parents have completed [REDACTED]. There were no recommendations for the father. The mother began [REDACTED] on March 25, 2013. The parents have been consistent in their participation with the Time Limited Family Reunification Program (TLFR). TLFR reports no observable concerns surrounding their ability to parent. The children are enrolled in [REDACTED] and both parents are currently employed. The family was also referred for a [REDACTED]. One area of continued concern is the family's ability to maintain stable housing.

As a result of a recommendation made during the Act 33 meeting held on December 5, 2012, the child's [REDACTED] was registered with [REDACTED] for investigation by the county agency. As a result of the [REDACTED], both parents were [REDACTED] of their child.

County strengths and deficiencies as identified by the County's (near) fatality report:

County Strengths: None noted

County Weaknesses: None noted

County Recommendations for Changes at the Local (County or State) Levels as Identified in County's Fatality Report:

It was recommended that the agency register a report with [REDACTED] regarding the [REDACTED] and that a CY104 (report to law enforcement) be completed to notify law enforcement of the hospital's [REDACTED] as mandated under [REDACTED] Law. The outcome of this recommendation has been addressed above in the Current Case Status section.

The panel also recommended that a meeting occur between the hospital administration and agency administration addressing the failure to report. The panel discussed the possible need for more education to be provided to medical staff regarding mandated reporting. At the very least, it was felt that this particular incident of failure to report be brought to the attention of the hospital administration (see Statutory and Regulatory Compliance section below for more information on the outcome of this recommendation).

Department of Public Welfare Findings:

County Strengths:

The county made efforts to keep the children with relative caretakers and to allow the relatives to supervise the parent's visitation with the children which has allowed for frequent, liberal visitation in the children's natural environment.

The county held the Act 33 meeting within the required timeframe.

County Weaknesses:

One significant, ongoing issue in Luzerne County is the lack of parental representation for court hearings which has resulted in numerous continuances and delays in court hearings. Although discussed at the judges' roundtable meetings monthly, there appears to be no resolution in sight. This issue has primarily continued due to the county's lack of funding issues.

Statutory and Regulatory Compliance Issues:

There were no statutory or regulatory compliance issues identified on the part of the county; however, the hospital's failure to report the child's [REDACTED] was identified as a result of the county's investigation and fatality review. This issue has been referred to the District Attorney's Office. A meeting is scheduled for Wednesday, May 15th between the District Attorney's Office, the Luzerne County CYS Director and Deputy Director and 3 area hospital administrators.