



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Cashmere Hill

Date of Birth: 9-23-07
Date of Death: 11-30-12
Date of Oral Report: 11-30-12

FAMILY NOT KNOWN TO:

Lehigh County

REPORT FINALIZED ON:

6/18/2013

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. 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. Lehigh County has convened a review team in accordance with Act 33 of 2008 related to this report, however the meeting was not held within the 30 day timeframe.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Mother	[REDACTED]-88
[REDACTED]	mother's paramour	[REDACTED]-91
[REDACTED]	twin sister to VC	[REDACTED]-07
Cashmiere Hill	victim child (VC)	09-23-07
[REDACTED]	sister to VC	[REDACTED]-12
[REDACTED]	father to VC *not a HHM	[REDACTED]-79

Notification of Child (Near) Fatality:

On 11/29/12, Lehigh County Children and Youth Services (LCCYS) received the near death report. VC was brought to the ER by ambulance/EMS. Mother reported that the VC had a tantrum 7 hours ago and hit his head on the toilet. When mother checked on the VC, she found the VC unresponsive and not breathing. Mother called 911. EMS report that VC had no pulse and was not breathing. VC had [REDACTED]. VC was given [REDACTED] and CPR. VC was [REDACTED]. VC had been [REDACTED]. VC was transferred to Lehigh Cedar Crest Hospital. [REDACTED] stated that VC has a [REDACTED]. VC had a [REDACTED]. VC also had a [REDACTED]. The treating doctor was concerned the injury was non-accidental, and certified the VC to be in critical condition. Police were notified. At that time it was unknown if VC would survive. The maternal grandmother was also at the mother's home the day of the incident. The treating doctor indicates that the child's injuries are not consistent with the mother's story. Mother let VC sleep for 4-5 hours before checking on him. Two hours later, the VC was unresponsive. VC had multiple bruises all over his body. Unknown if mother was questioned about the bruising on the VC at that time.

On 11-30-12, the VC died as a result of his injuries and the report was changed to a fatality report.

Summary of DPW Child (Near) Fatality Review Activities:

The Northeast Regional 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 County Internal Fatality Review Team meeting on 1-16-13.

Summary of Services to Family:

At the time of the VC's death, he had not been known to any children and youth agency. The child was attending [REDACTED] and was [REDACTED].

Children and Youth Involvement prior to Incident:

The case became known to LCCYS in October of 2007, shortly after the birth of [REDACTED] and his twin sister. Mother had [REDACTED] at that time. The case was closed in December of 2007. Mother provided a [REDACTED] and had support from her mother in caring for the children.

A subsequent referral came in regarding the family in December of 2008. The allegations were regarding [REDACTED] and inappropriate discipline. The allegations of inappropriate discipline could not be substantiated, and the maternal grandmother obtained an apartment across the hall in order to help her daughter with the children. The mother agreed if she was going to use marijuana, she would first take the children to their grandmother's. The case was closed in February of 2009. There were no other referrals made regarding this family prior to the death of the VC. Because the twins were [REDACTED], they were receiving [REDACTED] services at birth.

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

This case was brought to the attention of LCCYS again on 11-29-12, when they were notified of a near death report on the VC. On 11-30-12 the status of the case changed from near fatality to a fatality. A [REDACTED] law enforcement. An autopsy was performed later that day. A forensic interview was conducted with the VC's twin sibling on 11-30-13. This was a Child Advocacy Center interview observed by the caseworker and the police. The police also interviewed the mother's paramour on this date. On 12/3/13, the caseworker reviewed all [REDACTED] records on the VC and his sibling. The autopsy was completed and the coroner reported head trauma and other injuries on the VC. The cause of death was listed as Homicide, blunt force trauma. On the same date, there was [REDACTED]. On 12/10/12 [REDACTED]. Placement with the grandmother continued. On 1-16-13 an Act 33 meeting was convened to discuss the case. On 1-24-13 the case was [REDACTED]. The mother has been arrested on charges of criminal homicide and endangering the welfare of a child.

Current Case Status:

The children are currently residing with the maternal grandmother. Both surviving children are visiting their respective fathers and the fathers are working toward reunification with their children. Prior to this occurring, they will need to complete their respective service plan goals. The infant did have an [REDACTED] screening but required no services. The VC's twin continues to attend [REDACTED]. The mother has been arrested for homicide and endangering the welfare of children. She is currently in prison awaiting trial. The case continues to be monitored by LCCYS.

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

An Act 33 meeting was convened on January 16, 2013. This meeting was held over the 30 day time requirement. The LCCYS had not been recently involved with the family prior to the report of fatality on 11-30-12. The agency immediately took steps to ensure the safety of the other children in the home. The agency immediately located kin and made the grandmother an emergency kinship caregiver. The VC and twin sister's father was located very quickly, and visitation with the twin sibling was started. Visitation with the fathers in this case was provided immediately and the agency is working on reunification goals with both fathers. The agency has also offered supportive services to the grandmother.

During the Act 33 meeting, the team identified a need regarding [REDACTED]. While [REDACTED] had concerns regarding the care of the VC, these concerns were not shared with children and youth until after the VC's death. The team felt there could be a benefit in making [REDACTED] part of the review team. The team felt that establishing a liaison with the early childhood education community would potentially be a preventative measure by identifying children who appear at high risk for child abuse and neglect.

Department Review of County Internal Report:

The county report was received on 4-12-13. The NERO acceptance letter was sent on 4-17-13. The NERO agrees with the findings of the LCCYS. In this case NERO does not feel the LCCYS could have done anything further to prevent the fatality.

Department of Public Welfare Findings:

- **County Strengths:** The LCCYS immediately took steps to assure the safety of the other children. The absentee fathers were immediately located and visitation was set up immediately with the fathers. Appropriate kin was immediately identified and the siblings were placed together with the emergency caregiver. The agency coordinated efforts with the police and maintained a working relationship.

- County Weaknesses: Although, the LCCYS held an Act 33 meeting, the meeting was not held within 30 days of the oral report.
- Statutory and Regulatory Areas of Non-Compliance:
There were no regulatory compliance issues regarding this case.

Department of Public Welfare Recommendations:

- The LCCYS should continue to work with law enforcement regarding this case as well as future cases.
- The LCCYS should engage Head Start in discussions as to what and when it is appropriate to refer information to LCCYS.
- The LCCYS should look into other possible stakeholders who would be willing to be part of the Act 33 review.
- The LCCYS should consider scheduling Act 33 meetings as soon as report is received to ensure the meetings are held within 30 days of the oral report.