



REPORT ON THE FATALITY OF:

Novalee Wilner

Date of Birth: 01/09/15

Date of Death: 01/15/15

Date of Report to ChildLine: 01/15/15

CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILD WELFARE AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Schuylkill County Children and Youth Services (CYS)

REPORT FINALIZED ON:

October 7, 2015

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:

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, 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.

Act 33 of 2008 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. Schuylkill County has convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on 02/06/15.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Novalee Wilner	Victim Child (VC)	01/09/15
[REDACTED]*	Sibling	[REDACTED]/13
[REDACTED]*	Sibling	[REDACTED]/07
[REDACTED]*	Sibling	[REDACTED]/05
[REDACTED]*	Sibling	[REDACTED]/03
[REDACTED]*	Sibling	[REDACTED]/01
[REDACTED]*	Mother	[REDACTED]/85
[REDACTED]*	VCs Father	[REDACTED]/72

* 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 (Near) Fatality Review Activities:

The Northeast 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 Act 33 meeting held on 02/06/2015. A pediatrician, and all Schuylkill County Children and Youth Services' (CYS) staff who had been involved in the case were present. [REDACTED] involved in this case attended. There were also providers who participated in the meeting. NERO had the opportunity to interview staff at this time and spoke with all workers involved in this case.

Children and Youth Involvement prior to Incident:

Schuylkill County CYS has an extensive history with this family beginning on 8/25/09. This was related to behavioral concerns of the VC's mother's sibling who

was residing with the family. At that time, the mother had just moved to Schuylkill County. An intake was completed and it appeared that the mother was securing appropriate services on her own. The case was closed on 10/12/2009.

The family was again assessed on 02/22/10 due to issues regarding inappropriate discipline with the VC's mother's teenaged sister who was residing with her. The case was opened at that time. The case closed on 08/10/10 when the mother's sibling was [REDACTED]

On 11/12/10 the agency received a report with concerns of drug use by VC's mother and other individuals in the home and concerns that the mother's sibling [REDACTED]

[REDACTED] The adults in the home were drug tested with negative results and the mother's sibling was [REDACTED]. The case was closed 03/18/11.

On 01/17/13 the agency received a referral from Philadelphia Department of Human Services (DHS) as they [REDACTED] learned the family relocated back to Schuylkill County; concerns in Philadelphia County included drug use by the caretakers and inappropriate discipline. The family was assessed for agency services and opened due to concerns for positive drug screens, [REDACTED] with VC's mother and lack of follow through with medical appointments for VC's sibling following her birth [REDACTED] the hospital. The case remained open at that time.

In February 2014, [REDACTED] and a referral was made for [REDACTED] provider to assist the family with budgeting, parent/child conflict and scheduling appointments. The family continued to have difficulty providing for the children's basic needs. The VC's mother frequently missed medical appointments for the children and expressed difficulty coping with the behaviors of her children. In March 2014, there was a truancy referral on one of the children and reports of domestic violence in the home. [REDACTED]

[REDACTED] The paternal uncle had difficulty dealing with behaviors of the older two siblings [REDACTED]

From November 2014 until December 2014 the mother did not attend any [REDACTED]. In December 2014, the VC's mother re-engaged in [REDACTED] and reported she obtained a home. In December 2014 and January 2015, the VC's mother tested negative for illegal drugs. In December 2014, the agency learned the VC's mother was expecting another child and reported her due date as March 2015.

On 01/11/15 the agency received a referral stating the VC's mother gave birth to the VC on 01/09/15 and was [REDACTED] that day. The hospital reported no concerns with interaction between the VC and mother. Neither the VC nor the

mother tested positive for illegal drugs. On 1/12/15 an agency caseworker was sent to the home address where the VC's mother reported she was living. Entrance into the home was unsuccessful as no one answered the door. The agency caseworker attempted contact with the mother by phone with two telephone numbers the agency had on file. The mother answered one of the numbers and reported she was staying with a friend. The mother refused for the agency to meet with her and the VC that day but reported a visit could be made to the home 01/14/15 or during her [REDACTED] at [REDACTED] provider's office on 01/13/15.

On 1/13/15 another agency caseworker made an unannounced home visit to the address where mother was reportedly living. The caseworker was met by a woman who reported the mother was evicted from that home over one month ago due to suspicions of drugs but was reportedly staying down the street with a friend. The agency caseworker made an unannounced home visit to the new address and was told the mother lived there for one week about one month ago. The VC's mother was asked to leave the home due to concerns she was stealing money from them. The mother was then able to be contacted via telephone and provided the caseworker with an address where she was staying with the VC. The agency caseworker made a home visit with the mother, VC and home owners. The home owners reported the mother and VC could stay in their home and showed the agency caseworker a portable crib they were reportedly using for the VC to sleep. The mother had an appointment for VC to see the pediatrician later that day [REDACTED]. The agency caseworker had concerns the mother may have been co-sleeping with the VC as the mother slept on the sofa in the home. The agency caseworker addressed safe sleep with the mother and discussed the risks of practicing unsafe sleep practices. The VC's mother reported that the VC's father lives down the street with his adult children but helps her out financially. The homeowners reported they have a car and would help the mother get to her appointments for the VC. Following the home visit, the agency caseworker contacted [REDACTED] and suggested they also address safe sleep with mother during the supervised visit later in the evening. [REDACTED] provider later reported that she was able to meet with the mother and they reviewed safe sleeping.

Circumstances of Child Fatality and Related Case Activity:

On 1/15/15 the [REDACTED] responded to the family home and met the VC's mother, the home owners, and their three children. The mother was clearly upset over the VC's death. The mother reported she moved into the home 12/06/15 and [REDACTED] the hospital with the VC 01/11/15. The VC's mother reported she always slept on the sofa in the living room in this home while the home owners slept on the bed in the living room due to the male homeowner being [REDACTED]. The VC's mother and homeowners reported the homeowner's three children slept on the second floor of the home in their own bedrooms. The VC's mother and homeowners reported a portable crib was utilized for VC to sleep when she first came home from the hospital, however, on 01/14/15 a bassinet was obtained from the VC's father as the portable crib took up too much room.

[REDACTED] interviewed the VC's mother who reported the VC had been spitting up formula from her nose and mouth following feedings. The VC's mother reported concerns with her choking so she reported she had been positioning the VC in an upright position on the mother's chest following feedings. The home owners confirmed this as the female reported she often found the VC asleep on her mother's chest while mother was asleep upright. The female reported she had taken the VC off her mother's chest and placed her into the bassinet when asleep.

On the day in question, the VC's mother reported she fed the VC at 3:30AM and fell asleep by 4:00 AM. The VC's mother reported she was awoken around 6:30-6:45AM by the female home owner as the home owner noticed the VC to be on her back on her mother's chest. The female homeowner reported the VC was on her back between her mother's chest and the back of the couch. When awoken, the VC's mother noticed the VC was not breathing and the home owner called 911. The VC's mother confirmed that the Schuylkill County CYS staff and [REDACTED] provider both discussed safe sleeping with her, but she failed to follow the recommendations. A drug screen was performed on the VC's mother by [REDACTED] [REDACTED] which was negative.

An interview was completed with the agency caseworker and [REDACTED] provider who discussed safe sleep with the VC's mother. A discussion was held with the coroner on 01/30/15.

[REDACTED]

[REDACTED]

[REDACTED]. There are no criminal charges pending.

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

- Strengths in compliance with statutes, regulations and services to children and families;
The county held a timely and comprehensive Act 33 meeting on 02/06/15. At that meeting it was discussed how the caseworker who evaluated the mother's home reviewed safe sleeping and contacted another provider agency who was active with the family to review safe sleeping as well. This was seen as a strength by the team.

- Deficiencies in compliance with statutes, regulations and services to children and families;

There were concerns at this meeting regarding the mother being allowed to take this child home from the hospital [REDACTED]

[REDACTED]. This included concerns for the mother's [REDACTED]. There was also a concern regarding how information was transferred between workers involved in this case. A worker who was unfamiliar with the case was asked to check the home, but she had little background information. The team felt that if the worker had more information regarding the mother's background, it could have influenced her decision as to whether to leave the child in the home [REDACTED].

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

There were no recommendations for changes at the state level regarding this case. At the county level, Schuylkill County CYC reassessed some of their policies and procedures as a result of the Act 33 meeting. Following the Act 33 meeting the agency implemented an internal policy regarding all cases with pregnant women. All cases are to be reviewed internally at their court committee to discuss future agency plans. Additionally, an amendment was made to the on-call procedure for the assessment of all newborns. Any active or non-active referrals on call, regarding newborn babies are to have two supervisory reviews before determining final safety. An internal discussion was also held with supervisors regarding the weight of a child's removal based on risk, as well as safety.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

There were no recommendations for change at the state or local level regarding the inspection of county agencies.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

There were no recommendations for change regarding community collaboration in regards to preventing child abuse.

Department Review of County Internal Report:

NERO received the Schuylkill County Child Fatality Report on 06/23/15. DHS/NERO finds the county's internal report to be an accurate representation of the discussion at the Act 33 meeting. The County was sent a letter on 6/29/15, acknowledging receipt of the report.

Department of Human Services Findings:

- County Strengths: Schuylkill County CYC continues to have comprehensive Act 33 meetings. There is a willingness of all participants to openly discuss

the case and critically review the events leading up to the fatality/ near fatality. The agency appears to seriously evaluate the findings in these meetings and there is often an internal plan of correction following the reviews. Community stakeholders have also been active participants and there have been several community trainings that have been implemented as a direct result of the Act 33 meetings.

- County Weaknesses: The County did appear to have some communication issues regarding this case. Because the ongoing worker was on leave, other workers were filling in and it appears more could have been done through the supervisor to advise the workers involved of the background and concerns with this mother. [REDACTED]

[REDACTED] This appears to be related to the communication and the fact that the interim worker who completed the safety assessment did not have background information which could have helped in her decision making. The agency has recognized a need for assistance with safety assessments and has been participating in safety assessment support sessions over the last year.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency. While there were practice issues identified, and an internal plan of correction formulated, there were no regulatory or statutory violations identified regarding this case.

Department of Human Services Recommendations:

As mentioned earlier, the agency set forth an internal plan of correction after discussions at the Act 33 meeting. NERO concurs with the plan set forth by Schuylkill County CYS to more closely monitor newborn referrals within the agency.