



## **REPORT ON THE FATALITY OF:**

Anthony Dinozzo-Snyder

**Date of Birth: 08/25/2015**

**Date of Death: 12/07/2015**

**Date of Report to ChildLine: 12/08/2015**

**CWIS Referral ID: [REDACTED]**

### **FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:**

Lancaster County Children and Youth Services

**REPORT FINALIZED ON:  
6/1/16**

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:**

Pursuant to the Child Protective Services Law, 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.

The Child Protective Services Law 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.

Berks County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 01/05/2016 and again on 02/02/2016.

**Family Constellation:**

<u>First and Last Name:</u>	<u>Relationship:</u>	<u>Date of Birth</u>
Anthony Dinozzo-Snyder	Victim Child	08/25/2015
[REDACTED]	Biological Mother	[REDACTED] 1989
[REDACTED]	Biological Father	[REDACTED] 1978
[REDACTED]	Sibling	[REDACTED] 2009
[REDACTED]	Sibling	[REDACTED] 2014
* [REDACTED]	Oldest Sibling's Father	[REDACTED] 1986
* [REDACTED]	Paternal Grandmother	[REDACTED] 1955
* [REDACTED]	Step Paternal Grandfather	[REDACTED] 1965
* [REDACTED]	Biological Father's Ex-wife	[REDACTED] 1985
* [REDACTED]	Half-sibling	10 years old

\* 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 Fatality Review Activities:**

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed all current and past case records pertaining to the Snyder family. These records were obtained on 02/08/2015, 03/17/2016 and 04/21/2016. SERO conducted interviews of the Lancaster County Caseworker on 03/17/2016; the York County Caseworker 03/17/2016; and Berks County Caseworker, Casework Supervisor, and Intake Services Manager on 03/17/2016. SERO staff participated in the Act 33 meeting that occurred on 01/05/2016 and again on 02/02/2016 in which county and state child welfare professionals, medical professionals, community advocacy groups and law enforcement were present and provided information regarding the incident as well as historical information.

### **Children and Youth Involvement prior to Incident:**

06/12/1997 – Biological mother was involved as a child with York County CYS. She and all of her siblings were placed in foster care. All 5 children were returned to their mother's care in 1999 with wraparound services. Her mother moved in with a paramour in February of 2000 but that situation deteriorated resulting in her and her 5 children moving to [REDACTED] in July 2000.

07/13/2010 - York County CYS received a report for lack of supervision. Biological mother left older sibling who was then 1 outside in 100 degree weather for approximately 2 hours. He became red and sweaty, but no lasting harm or injury was done. This investigation was closed at intake.

11/07/2011 - York County CYS received a report for physical abuse on the victim child's oldest sibling but this report was screened out.

02/09/2015 – Lancaster County CYS received a report with the oldest sibling as the identified child. Child has missed a significant amount of school and family has moved from hotel to hotel. It was also alleged that the family was [REDACTED] unable to maintain safe housing. This report was opened for services with [REDACTED] services put in place. The case was officially closed on 06/02/2015.

There were no prior reports from Berks County.

### **Circumstances of Child Fatality and Related Case Activity:**

Berks County Children and Youth Services received a report on 12/07/2015 stating that the victim child was deceased. Biological mother reported that she was home with the three children upstairs in a bedroom watching TV. Victim child's next to oldest sibling was in a bassinet in the same room. Biological mother went downstairs to make a bottle when one of the children yelled for help. Biological mother came upstairs and saw that child Anthony was lying in his bassinet face up, alive but not breathing. She reportedly performed CPR for thirty minutes and then called 911. Emergency medical services responded to the home immediately and the child was already in a state of rigor mortis when they arrived. The family reported that the child had been sick for the past week and they were in the process of scheduling a doctor's appointment.

Medical records did indicate that the victim child was seen by a family physician on 11/12/2015. He also had well child examinations on 08/31/2015 and 09/23/2015. During the 11/12/2015 visit the biological mother stated the reason for visit as coughing, crying at night, pulling on ears, runny nose and difficulty breathing at night. [REDACTED] The victim child also had a temperature of 100.3 at that visit. [REDACTED]

[REDACTED]

Berks County Children and Youth Services (BCCYS) Emergency Duty made initial contact with the family on 12/07/2015. Biological mother was home alone with all three children while biological father was working. He was not home at the time of the child fatality. Biological father reported that he left the home at approximately 4:00 PM and nothing seemed out of the ordinary. Biological father said he last changed the victim child's diaper at 3:00 PM. Biological mother reported that she was in her bedroom with all of her children and the victim child was in his bassinet next to the bed. At approximately 7:52 PM biological mother reports going downstairs for about five minutes to get a bottle for the middle sibling. The oldest sibling reportedly yelled Mommy and she ran back upstairs and found child unresponsive but alive. Biological mother reported doing CPR for 30 minutes. After about 5 to 10 minutes of doing CPR, biological mother says she pushed the [REDACTED] emergency button on her cell phone which is a part of the [REDACTED] home security system. She said that she thought the button would immediately call 911 however [REDACTED] called and asked if there was an emergency. [REDACTED] then called 911. Biological mother reported that she found the child in the bassinet around 8:00 PM not breathing but biological father did not receive notification about the security button being pressed until 8:37 PM. EMS arrived at the home at 8:50 PM. Biological mother did not have an explanation for why her timeline was not consistent with the time log on biological father's phone or her account of providing CPR for 5 to 10 minutes.

The oldest sibling reported that he and the middle sibling were in the parents' bedroom but the victim child was in his crib in another room. He stated that he heard clicking noises coming from victim child's room so he went in to check on him. He reports the victim child having a bottle in his mouth and he knocked it out with his hand. Oldest sibling said that he became afraid and called for his mother. This is different from what he told [REDACTED].

Both parents stated that the victim child recently had an ear infection and at times had trouble breathing. They stated that they had concerns with the victim child's weight but said they told the doctor about it and he told them that he was healthy.

A safety plan was implemented stating that mother and father must be supervised at all times within ear and eye shot while interacting with their children as well as biological father's daughter by one of the following responsible people: Paternal Grandmother, Step Paternal Grandfather, Paternal Aunt and Father's Ex-Wife.

[REDACTED]

The safety plan was implemented on 12/07/2015. During the period between 12/07/2015 and 01/05/2016 Paternal Grandmother reported that she observed mother giving child [REDACTED] "strawberry milk" before bed and Paternal Grandmother

reported that she smelled the bottle and it had a very strong odor of medicine. Paternal Grandmother found Nyquil in the home and poured it down the drain. She did not report this to anyone or seek medical attention. When this came to the attention of BCCYS they placed both siblings on 01/05/2016 into a traditional foster home. Both siblings were drug tested at Reading Hospital on 01/07/2016 and were negative for all substances.

During the autopsy of the victim child at Reading Hospital the victim child's weight was recorded at 5.07 lbs. His birth weight was 4.6 lbs. He appeared to be thin and frail. His ribs and bones in his skull were able to be seen through his skin. Victim child did not have any fractures or signs of trauma to his body or organs. Formula was not found in the victim child's stomach and the doctor confirmed that rigor mortis would take approximately 4 to 5 hours to set in. The victim child would likely have been deceased 4 to 5 hours prior to EMS arriving to the home.

[REDACTED] were listed as alleged perpetrators in the report. The results of the autopsy concluded that the cause of death was homicide by acute doxylamine toxicity and chronic nutritional neglect. Doxylamine is an antihistamine found in Nyquil medicine. The paternal grandparents presented for kinship but were not approved. [REDACTED]

[REDACTED] The middle sibling is currently in a traditional foster home in [REDACTED], PA. The oldest sibling's custody has been transferred to his biological father's and he currently resides with him in [REDACTED], PA.

This case was [REDACTED] on 02/05/2106 for [REDACTED]

[REDACTED] Criminal charges have yet not been filed.

**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;

Siblings of victim child are in foster care with visitation from biological parents

The family has been receptive to services

A support system for the family has been identified

Lancaster County CYS participated in the Act 33 review

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

[REDACTED]  
A lack of appropriate parenting

There was a history of unstable housing and poor school attendance in Lancaster County

Paternal grandmother noted a smell of a foreign substance in the bottle and dumped the Nyquil out but didn't tell anyone or seek medical help  
The victim child had a low birthweight but was sent home from the hospital to the mother who had known risk factors [REDACTED]  
[REDACTED] without postpartum services or assessment

Mother has a history of multiple placements as a child  
Concern regarding the length of time between biological mother initiating CPR and calling 911 (rigor mortis present when EMS responded)

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

No recommendations

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

No recommendations

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

No recommendations

### **Department Review of County Internal Report:**

SERO reviewed the Berks County Child Fatality Team Draft on 02/08/2016. SERO concurred with all of the information in the report.

### **Department of Human Services Findings:**

- County Strengths:

The County Act 33 team reviewed the case more than once.  
A thorough investigation was conducted for this case.  
The County was able to find family supports and work with them to find permanency for the oldest sibling.  
The County monitored the safety plan closely and was able to place the children when necessary.

- County Weaknesses:

No weaknesses were identified in the investigation of this report.

- Statutory and Regulatory Areas of Non-Compliance by the County Agency:

There were no statutory or regulatory areas of non-compliance noted in this report.

**Department of Human Services Recommendations:**

There are no recommendations for this report. The County has conducted a thorough investigation and appropriately utilized family and community resources.