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**OFFICE OF CHILDREN, YOUTH AND FAMILIES
NORTHEAST REGIONAL OFFICE**

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REPORT ON THE FATALITY OF

Violet Williams

Date of Birth: September 17, 2009

Date of Fatality: January 24, 2010

**THE FAMILY WAS NOT KNOWN TO
LUZERNE COUNTY CHILDREN AND YOUTH**

REPORT DATED: June 4, 2010

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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect on December 30, 2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Violet Williams	Deceased Child	9 /17/09
[REDACTED]	Mother	[REDACTED]
[REDACTED]	Father	[REDACTED]
[REDACTED]	Paternal Grandmother	[REDACTED]

Notification of Fatality:

On January 22, 2010, [REDACTED], made a referral [REDACTED] regarding Violet Williams. Violet had been in the care of her paternal grandmother (PGM) who brought her to Wilkes-Barre General Hospital when she noticed that the child was not breathing and unresponsive. After extensive CPR and respiratory support were administered, Violet was transferred to Geisinger Hospital. The hospital performed an eye exam and found [REDACTED]. The child was not expected to survive and subsequently died 2 days later on January 24, 2010.

At the time of the referral from [REDACTED], it was unknown whether there was a medical explanation or abuse that caused the child's condition; however, an autopsy was performed on January 26, 2010 which concluded the cause of death as Sepsis.

Documents Reviewed and Individuals Interviewed:

The family was not known to the county children and youth agency prior to this report. The [REDACTED] was conducted by Luzerne County Children and Youth with initial assistance provided by Montour County Children and Youth who conducted the initial interviews, photographs and safety assessment. A copy of the [REDACTED] file was provided to the regional office for review at the conclusion of the investigation. The county agency [REDACTED] on January 28, 2010 less than one week from the receipt of the initial report; therefore, an internal review was not warranted.

Case Chronology:

January 22, 2010 – Luzerne County received a referral [REDACTED] [REDACTED] reported that the child was admitted to the Pediatric ICU [REDACTED]. The Luzerne County caseworker contacted Montour County Children and Youth to request a courtesy interview, photograph of the child and safety assessment.

January 23, 2010 - The caseworker contacted Geisinger Hospital to gather additional information, as well as make arrangements for the parents to be interviewed. The mother contacted the caseworker and agreed to submit to interviews with Montour County Children and Youth Services. Montour County provided the results of the interviews with the mother, father, and PGM to Luzerne County Children and Youth. Both mother and father gave accounts of their normal morning routine prior to father bringing the child to the PGM's. They gave a timeline of events from waking up to feeding the child and then father bringing the child to the PGM's home. There was nothing out of the ordinary and the baby was described as a happy, healthy baby. The PGM reported that the father dropped the child off at her home and the child slept most of the morning. When the PGM attempted to wake the baby in order to feed her, she was unresponsive. The PGM further stated that she attempted CPR and drove the child to the hospital.

January 24, 2010 - Luzerne County Children and Youth notified the Luzerne County District Attorney's Office of the referral. Geisinger Hospital pronounced the child dead at 10:00PM.

January 25, 2010 - Luzerne County Children and Youth staff went to the home of [REDACTED] [REDACTED]. Releases of information were signed. No interview was conducted as requested by law enforcement. The child was scheduled to undergo an autopsy on January 26, 2010 at 8AM. The agency retrieved the medical records of the child's birth, pediatrician's records and the ER record from the Wilkes-Barre General Hospital.

January 26, 2010 - Luzerne County Children and Youth Services sent a release of information to Geisinger Hospital to retrieve the child's medical records. The autopsy results determined the cause of death as sepsis.

January 28, 2010 – The [REDACTED] and the case is closed. An [REDACTED] /case closing letter is sent to the family and PGM.

Circumstances of Child's Fatality:

The child's father brought her to the paternal grandmother's (PGM) home at 7:30AM on January 22, 2010 as paternal grandmother was watching the child while the parent's were at work. The PGM stated that the child was sleeping and looked normal. At around 11:00AM, the PGM found the child had a change in color, was not breathing and was unresponsive. The PGM rushed the child to Wilkes-Barre General Hospital where extensive CPR and respiratory support was given. The child was then

transferred to the Pediatric Intensive Care Unit at Geisinger Hospital in Danville, PA. The child died of Sepsis on January 24, 2010. Violet was the family's only child.

Current / Most Recent Status of Case:

The [REDACTED] was completed on January 28, 2010. The [REDACTED] and the case was closed.

Statutory and Regulatory Compliance

As a result of the DPW review of the circumstances surrounding the child's death including the [REDACTED] case file, it was determined that the Luzerne County Children and Youth Agency was in full regulatory compliance. Upon initial notification, the agency made a referral to Montour County Children and Youth to conduct the initial safety assessment and interviews at Geisinger Hospital as required. The cause of death was quickly determined to be due to Sepsis; therefore, the assessment was completed within 6 days of the initial referral.

Findings:

- 1) The family was unknown to the Luzerne County Children and Youth Agency at the time of Violet's death.
- 2) Upon receipt of the referral, the agency made a request for a courtesy safety assessment and interviews with the mother, father and paternal grandmother from the county in which the child was hospitalized.
- 3) Violet Williams was an only child.
- 4) The cause of death was determined to be Sepsis.
- 5) The agency completed the [REDACTED] within 30 days, therefore, no internal child death review was required.

Recommendations:

- 1) Although no internal child death review was required in this case, the county must be prepared to not only convene a child death review team but establish a protocol for the preparation of a written report and the release of the written report as required by Act 33 of 2008. The current child death review team in Luzerne County has formally reviewed one child death to date; however, a written report has not yet been provided to the regional office.