pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

MAKAYLA DOYLE

Date of Birth: 12/16/12

Date of Death: 2/24/13

Date of Oral Report: 2/24/13

FAMILY NOT KNOWN TO:

Montgomery County Children & Youth

REPORT FINALIZED ON:
1/10/14

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. Montgomery County Children and Youth Services (CYS) convened a review team in accordance with Act 33 of 2008 related to this report on 3/22/13.

Family Constellation:

Name:	Relationship:	Date of Birth:
Doyle, Makayla	Victim Child	12/16/12
[redacted]	Mother	[redacted]/82
[redacted]	Father	[redacted]/84
[redacted]	Sister	[redacted]/11
* [redacted]	PGF	[redacted]/52
* [redacted]	SPGM	[redacted]/52
* [redacted]	PGM	Adult
* [redacted]	Paternal Aunt	Adult

*Non-Household Members

Notification of Child Fatality:

The child was taken to the hospital on 2/24/13 due to cardiac arrest. The child was deceased. The reporting source, [redacted] suspected abuse due to the child having [redacted] and bruises. It was reported that the child was in the care of her mother at the time of the incident, but it was uncertain how the incident occurred. There is also an older sibling who lives in the home. Montgomery County CYS was called. The father initially stated he was drunk and fell with baby, but later reported he and his wife were out drinking and left the children home alone. It was reported father appeared to be under the influence of alcohol when he was at the hospital.

Summary of DPW Child Fatality Review Activities:

The Southeast Region Office (SERO) of Children, Youth and Families obtained and reviewed all current case records pertaining to the family. SERO obtained and reviewed all current and past case records pertaining to the [redacted] family. Follow up interviews were conducted with the investigating caseworker, who determined the case to be [redacted] on 03/25/13. Follow up interviews were conducted with the Quality Assurance Administrator [redacted] and the Agency Director [redacted] on March 5, 2013, March 11, 2013, and May 31, 2013. SERO also participated in the County Internal Fatality Review Team meetings in March 2013.

Children and Youth Involvement prior to Incident:

The family was not previously known to Montgomery County Children and Youth Services.

Circumstances of Child Fatality and Related Case Activity:

On February 24, 2013, Montgomery County CYS received an immediate response [redacted] report alleging that the child suffered serious injuries from an unknown source. The incident date was reported as this same date, February 24, 2013. The child was pronounced dead on February 24, 2013 at 10:04 am. The report indicated that the child was transported to Abington Memorial Hospital's emergency room (ER) [redacted]. The child was located in the master bedroom, and the responding officer observed red swelling on the child's forehead and bruising and cuts on the bridge of her nose. She was later determined to have [redacted] as well as bruises. Montgomery County Detective Bureau Forensic Services Unit processed the crime scene at the apartment. Detectives noted remnants of a card game, with empty beer containers in the kitchen trash can and on the kitchen table. An infant swing was located in the living room of the apartment. The father reported he drank too much and fell on the child's body. The forensic pathologist performed an autopsy on 2/25/13. He noted that the child sustained several broken ribs, skull fractures and injuries to her nose consistent with pinching the child's nasal airway. The forensic pathologist concluded the child died as a result of Multiple Traumatic Injuries. The manner of death was ruled a homicide and the father was arrested and incarcerated. The mother was not charged. The child's older sibling was placed in the care of the paternal grandfather (PGM), [redacted] and his wife [redacted], step paternal grandmother (SPGM) as part of the Safety Plan. The child's sister was to be supervised 24/7 by the PGP's and the mother was not to be alone with her daughter.

Current Case Status:

[redacted] was arrested by [redacted] Police and charged with third degree murder. He is incarcerated at [redacted] Correctional Facility, awaiting trial.

The surviving sibling has been in the care of her mother in [redacted], MA, since March 20, 2013. They are residing with the maternal grandmother, who agreed to provide constant supervision of the child.

The paternal grandparents were unable to be a permanent resource with regards to the Safety Plan.

Montgomery County CYS closed the case on 3/20/13 and they made a referral to Massachusetts for follow up.

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

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. Montgomery County CYS has convened a review team in accordance with Act 33 of 2008 related to this report. The investigation was [redacted] within 30 days of receipt of the report.

- Strengths

Montgomery County utilized FGDM when caregivers (PGP's) struggled with the Safety Plan, and were able to identify caregivers who could assist the mother in caring for and supervising the other sibling.

- Deficiencies:

None Found

- Recommendations for Change at the Local Level:

Montgomery County will seek out programs that can provide treatment services to both Child Welfare and Adult Probation clientele. Adult batter's treatment programs should include an assessment of risk to children. Current practice is assessment of risk for re-offending to adults only.

Montgomery County CYS recommended that child care education and advocacy efforts should include information regarding the dangers of caring for children while intoxicated. Such information should be available where parents obtain information on caring for children, such as technology applications, videos in high school classrooms, and parenting or babysitting classes.

- Recommendations for Change at the State Level:

Child abuse prevention efforts should be reinforced by the Office of Child Development and Early Learning, the American Academy of Pediatrics, and the American Medical Association.

The Office of Developmental Disabilities should review supervision of consumers with family members and other caretakers when children are in the home.

Department Review of County Internal Report:

Montgomery County CYS received the report on 2/24/13. The family was not known to the agency. The record contained appropriate documentation of the family history. The Safety Plan and Investigations were completed within the appropriate intervals. The Department is in agreement with the findings of the county report.

Department of Public Welfare Findings:

- County Strengths:
  Collaboration with the medical team at Abington Memorial Hospital, along with the township police and forensics unit.

  Timely and quality safety plan and investigation.

- County Weaknesses:
  There were none found.

- Statutory and Regulatory Areas of Non-Compliance:
  There were none identified.

Department of Public Welfare Recommendations:

The Department is in agreement with Montgomery County CYS in that child care education and advocacy efforts should include information regarding the dangers of caring for children while intoxicated.

Child abuse prevention efforts should be reinforced by the Office of Child Development and Early Learning, the American Academy of Pediatrics, and the American Medical Association., pertaining to caring for children while under the influence of alcohol or other mind altering substances.