



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

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

Zoey Kearns

**Date of Birth:** September 1, 2014  
**Date of Death:** January 30, 2015  
**Date of Report:** February 3, 2015

### **FAMILY NOT KNOWN TO:**

Perry County Children and Youth Agency

### **REPORT FINALIZED ON:**

August 11, 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. Perry County Children and Youth Agency (CCYA) convened a review team in accordance with Act 33 of 2008 related to this report. The county review team was convened on February 18, 2015.

**Family Constellation:**

<u>First and Last Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
[REDACTED]	Mother	[REDACTED] 1998
[REDACTED]	Father	[REDACTED] 1997
Zoey Kearns (deceased)	victim child	09/01/2014
[REDACTED]	Maternal grandfather	[REDACTED] 1959
[REDACTED]	Maternal grandmother	[REDACTED] 1965
[REDACTED]	Paternal grandmother	unknown
* [REDACTED]	paternal aunt	unknown

\* 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.

**Notification of Child Fatality:**

On January 30, 2015, Perry CCYA was contacted by the [REDACTED] regarding the death of a child. It was reported that the child arrived "dead on arrival" at Harrisburg Hospital after being transported from the [REDACTED] residence. [REDACTED] requested that Perry CCYA meet them at Harrisburg Hospital to question the parents.

An autopsy was completed on January 31, 2015 and the results made available on February 3, 2015. The autopsy report stated that the child died of suffocation which was inconsistent with [REDACTED] account of the child's death. On February 3, 2015, based on the information from the autopsy report, Perry CCYA submitted [REDACTED] report [REDACTED]. However, this case was listed as a fatality report [REDACTED] on this date.

**Summary of DHS Child Fatality Review Activities:**

The Central Region Office of Children, Youth and Families (CERO) obtained and reviewed all current case records pertaining to the [REDACTED] family. CERO staff conducted interviews with the following Perry County staff: Administrator [REDACTED] and supervisor [REDACTED]. The Act 33 meeting was held on February 18, 2015 but a CERO staff was not present for this meeting because the report was not registered as a fatality at that time. Perry CCYA chose to convene the Act 33 meeting to ensure they were in compliance should the report later be deemed a fatality report. In attendance at that meeting were law enforcement, the District Attorney's office and the coroner's office and all provided information regarding the incident and their findings.

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

There was no prior involvement by Perry CCYA prior to this incident.

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

On January 30, 2015, Perry CCYA was contacted by the [REDACTED] [REDACTED] to accompany them to Harrisburg Hospital regarding the death of a child.

At the hospital, [REDACTED] met with the mother, father, paternal grandmother, paternal aunt and maternal grandparents. Each was spoken with separately regarding the circumstances leading to the child's death. Both the [REDACTED] and reside with [REDACTED]. The child resided primarily with the [REDACTED] but was with the [REDACTED] during the weekdays as [REDACTED] attended cyber high school and the [REDACTED] attended the local public high school.

The [REDACTED] reported that the [REDACTED] told [REDACTED] that [REDACTED] was having stomach issues and was in the bathroom for 15 - 20 minutes. [REDACTED] had placed the [REDACTED] in the bassinet before [REDACTED] went into the bathroom and [REDACTED] was crying. The [REDACTED] reported that the child eventually stopped crying. When the [REDACTED] came out of the bathroom a few minutes later, [REDACTED] found the child's head under the fringe ruffle in the bassinet and when [REDACTED] picked her up, she was blue and her arms were somewhat cold. [REDACTED] reported trying to administer CPR but was unsuccessful. [REDACTED] then called the [REDACTED] who lived nearby and [REDACTED] came over and also administered CPR with no success. An ambulance was then called.

[REDACTED] reported the exact same details as the [REDACTED] had just provided to [REDACTED]. There was no deviation of the details or sequence of events.

The [REDACTED] reported that the [REDACTED] had called [REDACTED] and said the child was unresponsive. When [REDACTED] got to the [REDACTED] home, [REDACTED] attempted CPR but was not successful. The [REDACTED] then waited with the [REDACTED] until the ambulance arrived.

The [REDACTED] and [REDACTED] had no information regarding the incident as they were not there. No one spoken with suspected that the [REDACTED]

would hurt the child intentionally. The [REDACTED] did report to [REDACTED] only that [REDACTED] had caught the [REDACTED] sleeping with the child on the couch once and had told [REDACTED] to never do that again.

The [REDACTED] and a [REDACTED] then met with [REDACTED] and [REDACTED]. The [REDACTED] discussed what the [REDACTED] had told [REDACTED] about the circumstances that led to the child's death. This story was consistent with what the [REDACTED] had reported to [REDACTED] and [REDACTED]. The exact cause of death would not be determined until after the autopsy was completed.

At this time, there was no indication made to Perry CCYA that the death was anything but accidental. No reports were made to ChildLine by [REDACTED], the [REDACTED] or the [REDACTED].

On January 31, 2015, the autopsy was completed and on February 3, 2015, the autopsy findings were available. The findings of the autopsy were inconsistent with the [REDACTED] story. The cause of death was suffocation and [REDACTED] were then suspicious that the [REDACTED] may have been co-sleeping with the child based on the [REDACTED] review of the [REDACTED] home on January 30, 2015. When [REDACTED] arrived at the [REDACTED] home after the death, they found blankets on the couch and the television on. Additional tests and medical records were requested and Perry CCYA [REDACTED]

[REDACTED] On this same date, Perry CCYA submitted an [REDACTED] regarding this case. There was no notification [REDACTED] that this case was registered as a fatality report. The case was listed as [REDACTED] on the Agency's case management system.

On February 17, 2015, [REDACTED] contacted Perry CCYA and advised that the [REDACTED] and [REDACTED] were spoken with again on February 15, 2015 and were told that the autopsy findings were inconsistent with the [REDACTED] explanation of the child's death. At that time, [REDACTED] admitted that [REDACTED] had lied initially and that [REDACTED] had fallen asleep in [REDACTED] bed with the child and when [REDACTED] woke up, the child was not breathing. [REDACTED] stated that [REDACTED] and the District Attorney's office were still considering this an accident and may not file any charges.

On February 18, 2015, an Act 33 meeting was held, despite the fact that this case was not registered as a fatality case. During the meeting, [REDACTED] and District Attorney's office reported that they are ruling the death accidental and no charges would be filed against the [REDACTED]. Perry CCYA also reported that this case would be [REDACTED] based on the information presented.

Interviews with the [REDACTED] and the [REDACTED] were then conducted by Perry CCYA. [REDACTED] admitted to lying initially because [REDACTED] was afraid. The [REDACTED] reported that [REDACTED] had fallen asleep with the child and when [REDACTED] woke up, the child was not breathing.

On March 23, 2015, Perry CCYA tried submitting their [REDACTED] but found they were unable to because the case was identified as [REDACTED] in the

[REDACTED]. After consultation [REDACTED], it was discovered that the case was not processed [REDACTED] on February 3, 2015 by ChildLine, but [REDACTED]. Based on the information, [REDACTED] and a fatality report on March 23, 2015 listing [REDACTED] as the alleged perpetrator. Since Perry CCYA had already investigated this case [REDACTED] and a fatality report, a final status determination [REDACTED] was submitted [REDACTED] on March 23, 2015.

**Current Case Status:**

Ongoing services were not warranted for the family as the parents have no other children. Perry CCYA provided [REDACTED] to the [REDACTED] and extended family members.

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

Strengths:

- Perry CCYA [REDACTED] interviewed the parents and extended family jointly immediately upon notification of the child's death.

Deficiencies:

- No deficiencies were noted.

Recommendations for change at the local level:

- None

Recommendations for change at the state level:

- None

**Department Review of County Internal Report:**

The CERO received Perry County's Child Fatality Report on April 24, 2015. Upon review of the report, the CERO requested that additional information regarding the strengths/deficiencies of the case be included in the report. Verbal feedback regarding the report was given to [REDACTED], on June 15, 2015.

**Department of Human Services Findings:**

County Strengths:

- Perry CCYA worked collaboratively with law enforcement and the coroner's office during the investigation.
- Perry CCYA treated the case as a fatality report even though it was not registered as one to ensure they were completing the process accurately for future cases.
- The investigation was completed in a timely manner.
- Perry CCYA provided appropriate resources for both families regarding [REDACTED]

County Weaknesses:

- Documentation of the Act 33 meeting should be more detailed and provide specific recommendations.

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

- No areas of non-compliance were noted.

**Department of Human Services Recommendations:**

- Perry CCYA should review and amend their Act 33 protocol and implement a documentation tool that accurately captures necessary information and recommendations provided during meetings.