



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Tanner Geiger

Date of Birth: 2-18-09
Date of Death: 10-15-13
Date of Oral Report: 10-09-13

FAMILY KNOWN or NOT KNOWN TO:

Not Known to Schuylkill County CYS

Known to Dauphin County CYS

REPORT FINALIZED ON:

03/01/15

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. 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, 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. Schuylkill County has convened a review team in accordance with Act 33 of 2008 related to this report. Dauphin County did not convene an Act 33 meeting within the regulatory timeline, nor did they attend the Act 33 meeting held by Schuylkill County. Dauphin County has an Act 33 review scheduled for 12/23/13.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Tanner Geiger	Child Victim (CV)	2/18/09
██████████	Maternal Grandmother	██████/66
██████████	Mother	██████/83
██████████*	Biological- father	deceased
██████████*	Grandmother's boyfriend at the time of incident, non HHM	

*Indicates that the individual was not a Household Member

Notification of Child (Near) Fatality:

On 10/9/13 Schuylkill County Children and Youth received a call from ██████████ reported CV was brought into the hospital earlier that morning due to ██████████. Hospital personnel were informed by the maternal grandmother that CV has separation anxiety and it has been suggested that he spend evenings away from his grandmother so he can get used to being around other people. As a result, CV spent the evening ██████████

The initial report provided was that CV was jumping on the bed at the AP's home and AP heard a thump. AP went upstairs and reportedly found CV unresponsive. AP changed ██████ story; however, and reported that CV's injuries were caused by ██████. AP reported that CV likes to bounce on the bed and ██████ was "rough housing" and bouncing CV on the bed. AP reported that ██████ picked up CV who was lying flat and dropped him onto the bed. AP stated that CV's head was close to the foot board and CV's head slammed into the divot of the footboard as CV landed.

AP reported that CV became unresponsive and was gurgling. AP reported [REDACTED] took CV downstairs to try to wake him and eventually called 911; at approximately 12:15AM. CV arrived at Geisinger Danville at 2:30 AM.

CV had significant head injuries which were not consistent with AP's reported mechanism of injury. CV had a [REDACTED] and evidenced "battle signs" which were reported to be [REDACTED]. The doctor reported a near fatality [REDACTED]. On 10/15/13 the child died due to injuries sustained [REDACTED].

Summary of DPW Child (Near) Fatality Review Activities:

Notification of the near fatality report was received on 10/09/13. On 10/15/13, the status changed due to the death of the child due to injuries suffered [REDACTED]. The preliminary report was completed by the Northeast Regional Office (NERO) on 10/10/13. NERO requested records at this time. [REDACTED]. The family was not known to Schuylkill County CYS, but preliminary reports state the mother had [REDACTED].

On 10/17/13, the assigned [REDACTED] worker received Dauphin County CYS involvement paperwork. On 10/17/13, an autopsy was completed on the CV. The results of the autopsy could take up to 8 weeks or more to be determined.

On 11/06/13, the County completed [REDACTED]. On 11/08/13, an Act 33 meeting was conducted in Schuylkill County. Dauphin County and the OCYF/Central Regional Office were invited to this meeting, but did not attend. NERO was in attendance at this meeting. Subsequent to the Act 33 meeting, Schuylkill County forwarded all medical reports, [REDACTED], pictures, etc. to the NERO for review.

On 11/15/13 the follow up report for Tanner Geiger was completed. On 12/23/13, an Act 33 meeting was conducted in Dauphin County. Schuylkill County participated by phone. Due to scheduling conflicts, NERO was unable to attend.

Children and Youth Involvement prior to Incident:

CV's mother, was known to Dauphin County Children and Youth since May 2008 due to concerns with drug use, criminal involvement [REDACTED] and unstable housing. [REDACTED]

CV was born 2/18/09 [REDACTED]. On 2/23/09 CV was [REDACTED] to his [REDACTED] father, [REDACTED]. The mother was only permitted supervised visits with CV and was not allowed to have overnight stays at [REDACTED] home. On 3/4/09 CV was [REDACTED].

[REDACTED] was not the father of CV. [REDACTED] was shocked but indicated he would continue to care for CV. On 4/6/09 [REDACTED] appeared at the Dauphin County Children and Youth office indicating he could no longer care for CV. On 4/6/09 CV was placed into foster care through Dauphin County Children and Youth.

Dauphin County Children and Youth met with [REDACTED] on 4/3/09. [REDACTED] provided a [REDACTED], but indicated he would care for CV. [REDACTED] began visitation with CV [REDACTED] the biological father of CV.

On 10/29/09 CV was discharged from foster care to his father, [REDACTED]. On 5/18/10 Dauphin County Children and Youth closed the case regarding CV. CV was in the care of his father, [REDACTED] upon case closure.

On 10/13/11, Dauphin County Children and Youth received a referral from [REDACTED] that [REDACTED] was brought into the emergency room for an [REDACTED] and [REDACTED] was present with CV. Hospital staff reported that [REDACTED]. Dauphin County Children and Youth met with CV, [REDACTED] and the paternal grandparents. A [REDACTED] placing CV in the supervision of his paternal grandmother and paternal great grandmother with a stipulation for no unsupervised contact between CV and his parents. It should be noted that [REDACTED] resided in the home of his mother and grandmother at the time.

[REDACTED]

On 5/10/12, Dauphin County Children and Youth received a referral of heroin use and abuse of [REDACTED] pills by Mr. [REDACTED] in the home of his mother. CV was residing in the home and the caller had concern for CV's [REDACTED] and paternal grandmother's minimization of use. Dauphin County Children and Youth met with CV, his father and paternal grandmother on several occasions to assess the concerns. On 6/4/12, CV was removed from that home [REDACTED] to his maternal grandmother and her husband. On 7/5/12, Dauphin County Children and Youth closed the case with CV. CV was in the care of the maternal grandmother at the time.

Circumstances of Child (Near) Fatality and Related Case Activity:

On 10/9/13 assigned [REDACTED] worker, [REDACTED] Schuylkill County, met with the [REDACTED] at [REDACTED]. The AP was provided [REDACTED] Miranda Rights and interviewed surrounding the circumstances of his last 24 hours. AP stated [REDACTED] woke at 12 AM on 10/8/13 and arrived at work at 1 AM. AP worked until 3 PM 10/8/13. After work, AP reported [REDACTED] went to Maternal Grandmother's (MGM)'s

home and played with CV for a bit in the yard. [REDACTED] visited with MGM until around 5:30 - 6:00 PM when [REDACTED] went to the local pizza shop for dinner. After dinner they returned to MGM's home to gather belongings for CV's sleepover [REDACTED].

AP reported [REDACTED] and CV arrived at his home between 8:00 – 9:00 PM on 10/8/13. The plan was for AP and CV to watch the movie Andre and to play a learning game "Go Fish" after CV's bath; however, CV played in the bathtub longer than expected. AP reported after CV's bath [REDACTED] gave CV a cupcake and put him to bed, around 10 PM. While CV was in bed AP did laundry. When AP returned upstairs to put the laundry away, CV was still awake. AP reported [REDACTED] began "rough housing" with CV in the bed to try and get him to sleep. He explained [REDACTED] was picking CV up and dropping him on the bed. AP reported the third time [REDACTED] dropped CV on the bed CV's head hit the foot board. AP explained CV required his assistance to sit up and CV's eyes fluttered. AP reported [REDACTED] took CV into the bathroom to splash water in his face and CV "gurgled." AP reported [REDACTED] took CV downstairs and called "911" around 12:15 AM on 10/9/13. AP reported [REDACTED] provided rescue breathing to CV as [REDACTED] did not think he was breathing. Police and EMS arrived and AP contacted MGM to inform her of CV's condition. AP reported [REDACTED] waited at his home for MGM to arrive and he drove her to [REDACTED].

MGM was interviewed after AP. MGM reported she and CV are very close; he calls her "mommy." MGM explained that CV was [REDACTED] and he has two siblings that are in [REDACTED]. MGM stated she and her ex-husband [REDACTED] when they lived in York County in Pennsylvania. MGM reported CV's father passed away of an overdose on 9/23/13. MGM said CV attends [REDACTED]. MGM stated she is seeking [REDACTED] services for CV through [REDACTED] as she believes he has [REDACTED]. MGM stated she uses time out for discipline with CV but described him as a very helpful boy. MGM reported she was informed by AP [REDACTED] was throwing CV up in the air above the bed and on one occasion CV landed with his head hitting the "U" in the footboard of the bed. MGM did not appear suspicious of AP's explanation during this interview.

[REDACTED] met with the [REDACTED] on 10/9/13. The [REDACTED] described the extent of CV's injuries, permitted photographs of CV in his current condition and discussed legal issues regarding custody and medical decisions for CV.

While [REDACTED] was at [REDACTED] [REDACTED] contacted the [REDACTED] police regarding their impression when responding to the home earlier that morning. [REDACTED] also contacted the Schuylkill County Communication Center and obtained a copy of the "911" call made by AP.

On the evening of 10/9/13 Schuylkill County Children and Youth (CYS) were contacted from [REDACTED] regarding CV's mother and her ability to obtain medical information regarding her son. [REDACTED] was at the hospital wanting to see her son and wanting a status on his condition. [REDACTED] was on call and explained to the knowledge of Schuylkill County CYS; [REDACTED].

[REDACTED], she should be permitted to see her child, due to his condition, and be provided a medical status. It should be noted, however, that MGM provided the hospital social worker a [REDACTED]

On 10/10/13, attempts to obtain information from Dauphin County Children Youth regarding CV and his family were initiated by [REDACTED]. Lebanon and York County CYS were also contacted by [REDACTED] on 10/10/13 to inquire if the family was ever active. Nothing was found.

On 10/10/13, [REDACTED] met with [REDACTED] at the Schuylkill County Children and Youth office. [REDACTED] was upset with the hospital's decision limiting her contact with her son. [REDACTED] provided a brief history of her involvement with Dauphin County CYS. [REDACTED] wanted confirmation Schuylkill County CYS was [REDACTED]

[REDACTED]

On 10/11/13, CV was examined by [REDACTED]
[REDACTED]
[REDACTED] MGM reacted appropriately and asked AP to leave the hospital upon his return [REDACTED] Grandmother initially felt it was an accident based on the explanation provided to her by the AP, but after talking to the doctor about the fact that it [REDACTED]

Due to concerns surrounding a [REDACTED]
[REDACTED]

On 10/11/13, [REDACTED] met with MGM in the evening at [REDACTED]
[REDACTED] Hospital staff contacted on call personnel as MGM wanted to talk with someone. MGM stated she received a call around 12 AM on 10/9/13 stating something happened to CV. She stated she questioned AP why they were up playing so late and why CV was jumping on the bed as he never did that at her home. She stated she has been encouraging AP to tell her everything about that night and [REDACTED]
[REDACTED] MGM stated AP has not told her anything more, but she thinks [REDACTED] got angry and lost it as he was awake for 24 hours with no sleep. MGM stated she never felt anything horrible could happen to CV with AP. AP sees CV daily at her home or at his home with her.

CV has spent the evening at AP's home with her and has even had a previous overnight visit on his own that went well. MGM did identify one occasion when CV told her AP spanked him and she reprimanded AP for disciplining CV without her permission. [REDACTED]

MGM discussed the night of the incident. MGM stated she and AP had been texting throughout the night, 10/8/13. AP text her CV took a bath at 8:30 PM for 45 minutes and did not want to get out. MGM stated that was odd as he never spends that long in the tub at her home. MGM stated she text AP who told CV, "Mama said you've been in the tub long enough, you have to get out." She received a text CV was given a cupcake at 10 PM and then was put to bed. She said she last received a text when AP put CV to bed and [REDACTED] went downstairs to fall asleep on the couch. MGM stated she finally received a phone call that AP heard a loud thud and scream and went upstairs to find CV on the bed; he had to call "911."

On 10/14/13, [REDACTED] interviewed MGM at [REDACTED] regarding her recollection of occurrences 10/7/13 and 10/8/13, up until the last time she saw him before CV left for [REDACTED]

On 10/14/13, Dauphin County CYS provided verbal information regarding their involvement with [REDACTED] and her son, CV. Additional written documentation was received, via email, from Dauphin County Children and Youth.

On 10/15/13, CV passed away [REDACTED]

[REDACTED]

[REDACTED]

Current Case Status:

Because the CV is deceased and there are no other children in the home, there will not be a case opened with Schuylkill County CYS. During the course of the investigation, the caseworker was made aware by the CV's mother that she was pregnant. This information was forwarded to Dauphin County CYS since the mother resides in the [REDACTED]. At the Dauphin County Act 33 meeting, there was reportedly a discussion about opening the mother for service.

[REDACTED]

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

- Strengths:

- Schuylkill County provided an in depth summary of past involvement in Dauphin County, as well as the current status of the case. Medical reports were reviewed, and the [REDACTED] police officer provided his perspective. The County caseworker worked closely with the hospital staff, as well as the police department, in order to make an informed decision regarding this case.
- One team member disclosed the fact that she was contacted [REDACTED] for information on grief counseling resources. Team members identified grief counseling resources in the community. Additionally, a video on grief and loss, geared toward younger children, produced by Sesame Street, was discussed. Discussion was held regarding the possibility of Schuylkill County CYS obtaining a copy of the video for future use.
- The Schuylkill County Act 33 team is very invested in the process and look at the meeting as a holistic process. They analyze what can be changed in the system in order to better protect the children in their community.

- Deficiencies:

- Dauphin County CYS and the Schuylkill County District Attorney's office were invited to the team review but did not attend. This was identified as a weakness. While the District Attorney has been an integral part of the team in the past, this meeting fell the day after the election. The present district attorney did not win the election [REDACTED]

The District Attorney elect was notified, but because she was not officially in office, she did not attend.

- Recommendations for Change at the Local Level:

- The team identified grief counseling for young children that they will be sharing with CYS.

- Recommendations for Change at the State Level:
- There were no recommendations made at the state level.
- Note: NERO reached out to the Central Regional Office (CERO) to try to obtain a copy of the Act 33 write up from Dauphin County. Dauphin County sent an MDT summary, which did not address the required areas of the Act 33 report. NERO was unable to obtain any further paperwork regarding Dauphin County's Act 33 meeting. The NERO requested follow up assistance from CERO.

Department Review of County Internal Report:

The County report was received on 12/06/13. On 12/13/13, the 45 day response to the county report was sent. The NERO concurred with the findings of the Schuylkill County team. While the team would have benefitted from input from the District Attorney and Dauphin County, they did not have the ability to compel these members to attend.

Department of Public Welfare Findings:

- County Strengths:
- The County continues to have a strong Act 33 review team. While the members do not place blame, they carefully analyze the evidence to see what can be done differently in the future to protect the children in the community. Several trainings and policy changes have been brought about in the county as a result of these team meetings.
- County Weaknesses:
- Other than the District Attorney's absence from this meeting (discussed above), there were no county weaknesses found. It should be noted that the county had no involvement with this family up until the time of the child's death.
- The team did discuss that Dauphin County appeared to have facilitated several private arrangements with this child and not offered Kinship care and extended services, but it appears that by all accounts, the grandmother was competent to raise this child and she likely would have obtained custody even if kinship was offered. It does not appear that this would have altered the outcome of the case.
- Statutory and Regulatory Areas of Non-Compliance:
- There were no statutory or regulatory areas of non-compliance noted in this review.

Department of Public Welfare Recommendations:

The county should reach out to the new District Attorney regarding the purpose of the Act 33 meetings and the importance of having representation from that office.