pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REPORT ON THE FATALITY OF:

Matthew Picarelli

Date of Birth: 1/28/96
Date of Death: 4/9/13
Date of Oral Report: 4/10/13

FAMILY NOT KNOWN TO:

Philadelphia Department of Human Services

REPORT FINALIZED ON:

01/17/2014

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))

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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. Bucks County did not convene a review team in accordance with Act 33 of 2008 related to this report, because the report [redacted]

Family Constellation:

Name:	Relationship:	Date of Birth:
Matthew Picarelli*	Child	01/28/1996
[redacted]	Mother	[redacted]/1959

*Matthew did not live in the home with his mother at the time of the incident, as he was placed at [redacted].

Notification of Child Fatality:

On 04/04/2013, staff at [redacted] became concerned when he did not get out of bed at 7:00 AM as per his usual, and he was still in bed at 9:00 PM An agency nurse took his vital signs and monitored his status throughout the day. [redacted] staff called 911 for an ambulance, and staff also contacted his mother, to inform her that he was being taken to [redacted] Hospital in the afternoon of 4/4/13. He was then transferred to [redacted] Hospital that evening, [redacted]. He passed away on 4/9/13, of a "massive posterior infarction of the brain, due to vertebral artery dissection, due to head banging," according to documentation from the Montgomery County Medical Examiner's office. On 4/9/13, [redacted], called the New Jersey Division of [redacted], as well as the New Jersey Department of Child Protection and Permanency (formerly called "DYFS"), alleging that [redacted] Matthew had passed away due to medical neglect and possibly abuse by staff at [redacted]. On 4/10/13, [redacted] called ChildLine to report allegations of child abuse, that staff had neglected to send Matthew to the hospital when he had symptoms on 4/2/13 and 4/3/13, and that staff had possibly hurt him.

Summary of DPW Child (Near) Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all records from [redacted], including a hospital stay from 10/31/12 to

[redacted]. Records from [redacted] Hospital, [redacted] Hospital, and also a report of an [redacted] from Matthew's Primary Care doctor, were reviewed. The report from the Medical Examiner's Office of Montgomery County was reviewed.

Calls were made to [redacted], Matthew's mother, on 4/10/13, and to her attorney, [redacted], on 4/10/13, as well as to [redacted] CEO [redacted] on 4/10/13. A [redacted] was completed and sent to the [redacted] Police Department on 4/11/13, and the police were verbally notified on that date as well. The case manager and supervisor at the New Jersey Division [redacted] and as well as staff from the New Jersey Department of Child Protection and Permanency, were interviewed on 4/11/13. Interviews were conducted with [redacted] staff on 4/16/13: The CEO, Quality Assurance Director, [redacted] Police Department, which was assisting the New Britain Township Police Department, was done on 4/17/13. Interviews with 3 direct care staff, as well as follow-up interviews with [redacted], Quality Assurance Director, and CEO, were conducted on 4/22/13. Relevant videos from the [redacted] were viewed on 4/22/13 at [redacted]. Staff from the Medical Examiner's Office of Montgomery County was interviewed on 4/26/13. The Attending Physician at [redacted] Hospital was interviewed on 4/30/13.

An unofficial fatality meeting was conducted over the phone on 5/6/13 during the Bucks County Act 33 review.

Children and Youth Involvement prior to Incident:

- According to staff from the New Jersey Department of Child Protection and Permanency, Matthew and his mother were known to the Department for several years, and [redacted] attempted to provide for Matthew's needs. No safety issues were noted, but DYFS staff were communicating with [redacted] in the event that she required assistance.
- Around 10/30/12, during Hurricane Sandy, Matthew was hospitalized at Kennedy Krieger Center, where he became upset about not having access to television during the hurricane.
- [redacted] In-home services were implemented through a local agency.
- On 2/17/13, police were called to Matthew's house, because he was attacking his mother. Reportedly, he was "chewing" on the back of her scalp.
- On 2/18/13, he was admitted to the [redacted], specializing in [redacted] at [redacted]

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

- After Matthew's [redacted] on 2/18/13, it was noted that he did severe head banging, [redacted] staff instituted a

new program that involved fewer changes in his day. His mother became overwhelmed from receiving so many calls about Matthew's care, [redacted]. A new procedure was implemented, allowing [redacted] staff to call his mother every day at 4pm to discuss his day. It was also noted that Matthew often "walked funny."

- On 3/28/13, Matthew was taken to his family dentist in New Jersey [redacted].
- On 4/4/13, Matthew had not gotten out of bed by 9:00 AM, so staff alerted the nurse, who came to take his vital signs. She sat with him for some time to monitor his vital signs.
- At 3:00 PM on 4/4/13, Matthew's favorite 1:1 staff came to work, and noticed that Matthew had not come to the staff person to get his shower.
- At 4:00 PM on 4/4/13, [redacted] staff contacted Matthew's mother, and discussed Matthew's medical status, and the reasons for calling an ambulance.
- At 4:00 PM on 4/4/13, Matthew was taken to [redacted] Hospital by ambulance, where he received multiple tests and exams to determine a diagnosis.
- At 8:00 PM on 4/4/13, Matthew was transferred to [redacted] Hospital.
- On 4/9/13, Matthew passed away [redacted].
- On 4/26/13, the Montgomery County Medical Examiner's Office sent SERO a "Cause of Death" statement, which stated that Matthew's death was caused by "massive posterior circulation infarction of the brain, due to vertebral artery dissection, due to head banging." Medical investigation staff explained that the motion of the head banging, not the impact of the wall on his head, was what damaged him, and that this condition is very rare.
- Matthew's [redacted] Physician at Abington Memorial Hospital stated to SERO on 4/30/13 that Matthew had a number of risk factors associated with this rare condition, including head banging, a recent dental care, and a type of spinning dance that he would do, and that any one of these factors could have injured Matthew. He stated that there was no way to determine the date of the injury, and that staff would not necessarily have been aware that the injury occurred, as he would not have shown any signs or symptoms of injury. [redacted] He stated that there was nothing that staff could have done to help him, if they did not know about the injury.
- The case was determined to be [redacted] on 5/8/13, and [redacted] was signed on that date.

Current Case Status:

- Matthew did not have siblings.
- No criminal charges have been filed, as [redacted] Police Department ([redacted] Police Department) determined that there was no criminal liability.
- [redacted]

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

In this case, a review was not required, as the allegation was [redacted] within 30 days of the report to the regional office.

- Strengths: None
- Deficiencies: None
- Recommendations for Change at the Local Level: None
- Recommendations for Change at the State Level: None

Department Review of County Internal Report:

None

Department of Public Welfare Findings:

- Agency Strengths: [redacted] staff were extremely cooperative, open, and staff were honest about their [redacted]. From discussions with numerous staff, and a review of the records, Matthew's services demonstrated that staff changed the program to fit his needs, and staff were committed to caring for Matthew. An astonishing amount of time, energy, effort, [redacted] were devoted to caring for Matthew at [redacted]. All staff expressed sadness regarding his passing.
- Agency Weaknesses: None
- Statutory and Regulatory Areas of Non-Compliance:
  The Southeast Regional Office of Children, Youth and Families [redacted], nor does it license the [redacted] Facility operated by [redacted]. The licensing bodies for [redacted] facility were contacted about the allegations. No statutory or regulatory issues were noted during the investigation.

Department of Public Welfare Recommendations:

None