



REPORT ON THE FATALITY OF:

Nathaniel Rivera

Date of Birth: 08/28/2015

Date of Death: 01/13/2016

Date of Report to ChildLine: 01/13/2016

CWIS Referral ID: [REDACTED]

FAMILY KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Berks County Children & Youth Services

REPORT FINALIZED ON:

08/02/2016

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:

Pursuant to the Child Protective Services Law, 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.

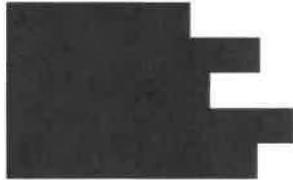
The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Berks County Children & Youth Services (Berks County CYC) has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was convened on 03/02/2016.

Family Constellation:

First and Last Name:

Nathaniel Rivera



Relationship:

- victim child
- mother
- father
- brother
- sister
- sister

Date of Birth:

- 08/28/2015
- 1981
- 1993
- 2006
- 2012
- 2010

Summary of OCYF Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families (SERO) obtained and reviewed current and past case documentation pertaining to the family. Follow up interviews were conducted with caseworkers on 06/01/2016 and 06/02/2016. The regional office also participated in the County Fatality Review Team meeting on 03/02/2016.

Children and Youth Involvement prior to Incident:

This family was previously known to Berks County CYC. In September 2006, mother’s parenting abilities without adult assistance were questioned; however, this incident was investigated and closed at intake. February 2010, a report was received regarding one of the victim child’s siblings using inappropriate language and the mother having sex in front of the sibling. There was no investigation completed on these concerns. June 2011, Berks County CYC investigated a call due to another of the child’s siblings receiving a hematoma on her forehead on 06/20/2011, and another one in the same location but larger on 06/21/2011, due to falling out of a baby carrier and falling off of the bed onto a glass of iced tea.

Berks County CYS put provider services in the home to work with mother. A second referral was received in August 2011 regarding these same concerns. During this second investigation, Berks County CYS was informed that the sibling had pulled a DVD player by the cord onto her head; mother did not take her to the doctor. All incidents were investigated and Berks County CYS opened services due to lack of supervision and lack of supports to mother. Additional concerns were received for the family during the time that the family was receiving ongoing [REDACTED] services. These concerns included: mother's parenting skills were being questioned due to reports of physically disciplining her children, anger issues, poor housekeeping issues and currently being pregnant. Berks County CYS did not investigate these concerns as a separate referral. February 2014, concerns were received for unsanitary home conditions; that the mother was refusing to take one of the child's siblings to the hospital due to redness to her vagina; and that the mother had mental health concerns. Berks County CYS did not investigate these concerns. May 2014, Berks County received a call stating that abuse was occurring and the home was not safe and clutter was everywhere. Berks County CYS investigated this allegation and the case was closed in intake. April 2015, concerns were received for domestic violence and physical abuse to one of the child's siblings. This report was investigated and closed at the intake level. In May 2015, Berks County CYS received a report stating that two of the child's siblings were being supervised by friends of the mother who were not aware that children were not in their residence. Police picked up the children and handed them to their mother. This incident was closed in intake. In October 2015 the 3 year old child had several bruises and it was alleged that she received these bruises from her older sister. Both children and mother were not clean and had a foul odor; however, the victim child was clean. Mother declined to receive services for domestic violence. Also while this report was being investigated mother allowed victim child's younger sisters to hold him and they along with mother had dropped him. These allegations were investigated and the family was opened for services [REDACTED].

Circumstances of Child Fatality and Related Case Activity:

On 01/11/2016, the victim child was taken to St. Joe's emergency room as he was experiencing diarrhea and vomiting; however, mother expressed that St. Joe's sent them home stating that there was nothing wrong with the child. However, it was later noted that mother left the hospital against medical advice. On 01/12/2016, the victim child was experiencing the same symptoms of illness, so his mother and father were giving him Pedialyte. Approximately one hour later, the child became increasingly lethargic and the mother noticed that his heart rate, which has been fast all day, was slow. That evening, the mother and the child fell asleep on the mother's bed with the child lying on the right side of the mother. The mother reported that she awoke around midnight on 01/13/2016 and called 911 due to the child being pale with purple lips and feeling clammy. At approximately 12:07 AM CPR was started. When emergency medical services arrived at 12:08 AM, the victim child was [REDACTED] CPR was performed, [REDACTED] The victim child passed away around one hour later at the Reading Hospital Memorial

Center. Cause of death was ruled as sudden and unexplained death in infancy associated with co-sleeping.

It should also be noted that the parents provided different details regarding various events on 01/12/2016; including the following: the times individuals in the home woke up, the family's activities throughout the day, and the condition that the child was in at various times throughout the day.

Due to the fatality a safety plan was put into place for victim child's female siblings to stay with the mother's friend. The victim child's brother was already residing with his maternal grandmother who has custody of him. [REDACTED]

[REDACTED] Mother is receiving parenting education and [REDACTED] Mother is being scheduled for [REDACTED] as well.

This case was indicated on 03/10/2016, for causing the death of child through any act/failure to act. The [REDACTED] was named as the perpetrator. There are no criminal charges; police never reported to the crime scene.

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

- Strengths in compliance with statutes, regulations and services to children and families;

None noted

- Deficiencies in compliance with statutes, regulations and services to children and families;

None noted

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;

None noted

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and

None noted

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.

None noted

Department Review of County Internal Report:

County report holds a lot of information regarding prior history of family, very detailed.

Department of Human Services Findings:

- County Strengths:

Very detailed investigation

- County Weaknesses: and

None noted

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

None noted

Department of Human Services Recommendations:

Public service announcements should be made that encourage parents not to co-sleep with infants due to the potential consequences of co-sleeping. There should also be brochures distributed to new parents in the hospitals and pediatrician offices that provide information on the dangers surrounding co-sleeping.