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REPORT ON THE FATALITY OF

GABRIELLA GEIST

BORN: July 7, 2010
DATE OF FATALITY: August 19, 2010

FAMILY KNOWN TO: Lehigh County Children and Youth Services

DATED: May 13, 2011

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.
(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 No. 1147, now known as Act 33 was signed by Governor Rendell on July 3, 2008 and went into effect 180 days from that date, December 31,2008. This Act amends the Child Protective Services Law (CPSL) and sets standards for reviewing and reporting child fatality and near child fatality as a result of suspected child abuse. DPW must conduct child fatality and near fatality reviews and provide a written report on any child fatality or near fatality where child abuse is suspected.

Family Constellation:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>
Gabriella Geist	Victim Child	07/07/2010
[REDACTED]	Father	[REDACTED]
[REDACTED]	Mother	[REDACTED]
[REDACTED]	Family Friend	[REDACTED]

Notification of Fatality:

[REDACTED] received the [REDACTED] regarding the death of the child on August 20, 2010 and the [REDACTED] was sent to the Northeast Regional Office on that date as well. [REDACTED] was the [REDACTED] reported that [REDACTED] was told that the mother and father of the victim child were in the bedroom while the child was in her pack and play in the bedroom as well. The father got up to get a cigarette and noticed frothy blood coming from the child's mouth. He yelled for an uncle who came into the bedroom and called 911. Around 5:00 pm on August 19, 2010, Emergency medical services responded and took the child to Sacred Heart Hospital. The child was deceased at the home. Law enforcement was [REDACTED]. There were no outward signs of [REDACTED] and X-rays were taken. An autopsy was scheduled for August 20, 2010. [REDACTED] Lehigh County Children and Youth Services received this report on August 20, 2010.

Documents Reviewed and Individuals Interviewed:

The Northeast Regional Office Program Representative reviewed the [REDACTED] case file and the prior referrals on the family. The Program Representative met with the [REDACTED] supervisor, caseworker, and administrator regarding the case. The [REDACTED] supervisor and caseworker were spoken to as well regarding their prior involvement with the family.

Case Chronology:

07/07/2010

The [REDACTED] of Lehigh County Children and Youth Services received a referral regarding the [REDACTED] family. [REDACTED]

07/08/2010

The assigned agency caseworker met with the family at the hospital to review the allegations with the [REDACTED] family. The child had [REDACTED] and was in the [REDACTED]. The caseworker made a verbal safety plan with the parents for the father not to have any unsupervised contact with the child [REDACTED]. A preliminary safety assessment was completed by the [REDACTED] assigned caseworker with a determination that the child was safe.

07/11/2010

The assigned caseworker had telephone contact with the [REDACTED] who reported that the child appears to be healthy and had a diaper rash which could have occurred as a result of [REDACTED] in the hospital.

07/12/2010

The assigned caseworker made an unannounced home visit to the family but the family was not home.

07/14/2010

The assigned caseworker conducted an unannounced home visit and met with the family and saw the child. According to the caseworker, the child appeared healthy.

07/22/2010

The caseworker made an unannounced visit to the [REDACTED] family residence. The child appeared well and the family had plenty of diapers and formula for the child. The caseworker reviewed the [REDACTED]

08/04/2010

An announced home visit was scheduled by the caseworker to the [REDACTED] family residence. The child was seen and noted to be doing well. The family discussed seeking alternate housing due to some physical issues with the residence regarding issues with the landlord, cockroaches and general repairs.

08/19/2010

The death of the child occurred. 911 were called by an uncle as the child was reported to have frothy blood coming from her mouth. The child was taken to Sacred Heart Hospital by emergency services personnel

08/20/2010

[REDACTED] received the oral report made by [REDACTED]. Lehigh County Children and Youth Services were notified of the [REDACTED] the death of the child. [REDACTED] faxed to the Northeast Regional Office.

08/20/2010

A Lehigh County [REDACTED] caseworker was assigned [REDACTED]

08/20/2010

CY 104 sent to law enforcement by Lehigh County [REDACTED] Caseworker.

09/17/2010

[REDACTED]

09/29/2010

Multidisciplinary team meeting held at Lehigh County with no recommendations made by the team.

Previous Children and Youth Involvement:

The agency had prior involvement with the family at the [REDACTED] level as of July 7, 2010. Initially, the allegations were that the father was awaiting sentencing on [REDACTED] charges. A second referral was received several days later stating that the family needed to use an air conditioner for the child. Also, the report stated that the parents were smoking around the child. The allegations were reported by [REDACTED]. There were also referrals received by the agency regarding the child having diaper rash. The child was seen medically to rule out any issues of neglect. The child did have diaper rash [REDACTED].

The case was being assessed by the [REDACTED] caseworker due to allegations received by the agency and the family was also seeking alternate housing as they wanted to change the area where they lived. The mother of the victim child had been in the [REDACTED] in Northampton County and the father had been in the [REDACTED] in Lehigh County.

A parenting program was put in place by the hospital to assist the new parents with information regarding the care and the development of their infant. This parent advocate was a monthly in home service. The philosophy of this program is to build on family strengths and foster an environment that is stable and able to provide nurturing and child care safely. The family was involved with this service.

The caseworker reported that during home visits both announced and unannounced that the child always appeared well cared for.

Circumstances of the Child's Fatality:

The maternal grandmother had been feeding the child while the parents had left the residence earlier in the day to get lunch. When the parents had returned, they noticed that the baby was fussy. The maternal grandmother had placed the child in the pack and play at that time.

The mother and father of the victim child were in the bedroom at the time of the incident. The child was in the pack and play in the bedroom as well. The father got up from the bed and noticed that frothy blood was coming from the child's mouth. He called to a family friend who resided with them and he called 911 at approximately 4:50 p.m. Emergency medical services responded and took the child to Sacred Heart Hospital in Allentown. The child was pronounced dead at the hospital. [REDACTED] An autopsy was

conducted on August 20, 2010. The cause of death was determined to be Sudden Infant Death with Hydrocephalus, due to aqueductal stenosis/glicosis and multiple cardiac anomalies.

[REDACTED]

Law enforcement closed their investigation with no criminal charges pending

[REDACTED]

Current / Most Recent Status of Case:

The case [REDACTED] by Lehigh County Children and Youth Services as it was established by the coroner and medical personnel that the child's death was due to natural causes. The case was closed by the agency as there were no other children in the family's home. The agency was working with the family as they wanted to obtain alternate housing. The visiting nurse through St. Luke's Hospital was also involved in assisting the family with the infant.

The father does have another child who resides with the biological mother of that child in another county. The father is reported to have no contact with that child. Law enforcement closed their investigation regarding this case with no charges pending as the child's death was due to natural causes. Friends and family were supportive of the couple and their loss and provided financial assistance in regard to funeral expenses.

[REDACTED]

The case was closed by the agency as there were no other children residing in the home. The agency provided information regarding [REDACTED]. The family agreed that they would deal with [REDACTED] if they felt that it was necessary.

Statutory and Regulatory Compliance:

The [REDACTED] caseworker formulated a verbal safety plan with the family that the father would not have any unsupervised contact with his daughter. This was formulated on July 8, 2010 at the initial referral [REDACTED]

[REDACTED] However, the safety assessment reflects that the child was determined to be safe. The Northeast Regional Office Program Representative discussed this issue at length with the management team at Lehigh County Children and Youth Services. This practice was again reviewed with staff by the Lehigh County Program Specialist in charge of staff training.

A risk assessment was not completed at the conclusion of the investigation as there weren't any children residing in the home. Therefore, the case was closed.

Findings:

The agency did not have to conduct an internal review and complete a report [REDACTED] [REDACTED]. The agency did conduct a multidisciplinary team meeting to discuss the case and to review the agency's handling of the case. The pediatrician on the agency team reviewed the medical condition of the child and discussed that the condition was unable to be detected at birth. The multidisciplinary team did not make any recommendations.

Recommendations:

The recommendation that was made by the Northeast Regional office related to the need for agency supervisory staff to carefully review the case notes and safety assessments to ensure that staff are utilizing the safety assessment tool appropriately and not formulating verbal safety plans. It is recommended that the Quality Assurance Program Manager be utilized in this process as well as the safety lead. Future trainings are planned with the county supervisory staff that will be lead by the Child Welfare Training program in conjunction with the regional office.