



Jacquelyn Maddon
Regional Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

(570) 963-4376
Fax (570) 963-3453

**OFFICE OF CHILDREN, YOUTH AND FAMILIES
NORTHEAST REGIONAL OFFICE
Scranton State Office Building
100 Lackawanna Avenue
Scranton, Pennsylvania 18503**

REPORT ON THE FATALITY OF:

Kayla Figard

**BORN: 11/12/10
Date of Fatality: 10/30/11**

**FAMILY KNOWN TO:
Berks County Children & Youth**

Unknown to Schuylkill County Children and Youth

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 on July 3, 2008 and went into effect 180 days from that date, December 30, 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>
Kayla Figard [REDACTED]	Victim Child (VC) [REDACTED]	11/12/10 [REDACTED]/82 [REDACTED]/94 [REDACTED]/09 [REDACTED]/84

Notification of Child Fatality:

On 10/26/11, [REDACTED] of the [REDACTED] Police Department contacted the Schuylkill County Children and Youth Services (SCCYS). [REDACTED] reported the [REDACTED] Police and Ambulance were dispatched to [REDACTED]. Upon arrival, the victim child (VC) was found to be in full cardiac arrest. CPR was initiated and VC was transported to Schuylkill Medical Center, South Jackson where she was [REDACTED] flown to Geisinger Medical Center of Danville for further treatment.

On 10/27/11, Caseworker (CW) [REDACTED] received [REDACTED] reports from Schuylkill Medical Center. The records showed that the VC [REDACTED]. During the 10/20/11 visit, it was recommended by [REDACTED]. The VC's mother [REDACTED]. The case was subsequently called to [REDACTED] (regarding the 10/26/11 incident) and [REDACTED].

On 10/27/11, upon receipt of the [REDACTED], SCCYS CW [REDACTED] was assigned the case. SCCYS CW [REDACTED] initially met with the VC's mother on 10/27/11 and informed her [REDACTED]. CW [REDACTED] contacted the [REDACTED] as well as [REDACTED] Police Department about the [REDACTED]. Contact was made to Geisinger Medical Center of Danville to obtain an update on VC's condition. It was at this time, the agency was notified [REDACTED]. SCCYS CW [REDACTED] traveled to Geisinger Medical Center to meet with the VC, family members, and hospital staff. Upon arrival, SCCYS CW [REDACTED] met with [REDACTED], who informed him the VC's family was currently meeting with doctors to discuss the VC's current status and a treatment plan.

[REDACTED] reported the VC had [REDACTED]. The VC was reported to have [REDACTED] reported the hospital's recommendation would be to wait 72 hours to assess [REDACTED].

The agency was notified on 10/30/11 that the VC had passed away at 7:42 p.m. [REDACTED].

Schuylkill County requested testing [REDACTED] but there were [REDACTED]. By that time, [REDACTED]. An autopsy was performed and the cause of death was undetermined.

Summary of DPW Child Fatality Review Activities:

Northeast Regional Office (NERO) staff reviewed the information gathered for the child abuse investigation including [REDACTED] on both the VC and her older sibling. NERO staff also reviewed [REDACTED] and all interviews conducted by children and youth. In addition, NERO staff attended the Schuylkill County Act 33 team review meeting held on 11/22/11. For interview schedule, please see chronology below. On 10/09/12, Berks County held their Act 33 team review meeting. Representatives from NERO and Schuylkill County were in attendance.

Summary of Services to the Family:

The family was not known to SCCYS prior to this incident. The family was known to Berks County Children & Youth Services (BCCYS). On 3/15/10, [REDACTED] at BCCYS regarding [REDACTED]. The family participated in [REDACTED]. The family was cooperative and successfully completed the [REDACTED] and the case was closed 4/13/10.

On 8/13/10, a referral was made to BCCYS regarding the [REDACTED], however it was listed as information only.

On 8/20/10, BCCYS received a referral regarding the VC's mother [REDACTED]. This was listed as information only because she was an adult and not living in the home. However, [REDACTED].

On 9/28/10, a referral was made to BCCYS regarding [REDACTED]. There were no children residing with victim child's mother at this time. This was listed as information only.

On 11/13/10, a referral was made to BCCYS [REDACTED]. Therefore it was listed as information only. This was discussed at the Berks County Act 33 meeting. The referral [REDACTED].

On 10/27/11, [REDACTED] SCCYS CW [REDACTED] was assigned the case. SCCYS CW [REDACTED] initially met with the VC's mother on 10/27/11 and informed her [REDACTED]. SCCYS CW [REDACTED] contacted the [REDACTED] as well as [REDACTED] Police Department about the [REDACTED]. Contact was made to Geisinger Medical Center of Danville to obtain an update into [REDACTED] condition. It was at this time, that SCCYS was notified the VC [REDACTED]. SCCYS CW [REDACTED] traveled to Geisinger Medical Center to meet with the VC, family members, and hospital staff. Upon arrival, SCCYS CW [REDACTED] met with [REDACTED], who informed him the VC's family was currently meeting with doctors to discuss the VC's [REDACTED]. [REDACTED] reported the VC had [REDACTED]. The VC was [REDACTED]. [REDACTED] reported the [REDACTED].

SCCYS CW [REDACTED] supervisor, [REDACTED], was reviewing the [REDACTED]. Further research was completed and it was learned a sibling lived with his father in Reading, PA. BCCYS was contacted and a request for a safety assessment was requested. BCCYS reported prior involvement with the family as discussed earlier in this report. BCCYS was able to make contact with the child and his father and it was deemed to be safe and appropriate for him to remain with his father.

The VC's father contacted SCCYS CW [REDACTED] and reported concerns of the VC [REDACTED]. He reported while VC's older brother was in the care of his mother he had reportedly [REDACTED]. He reported the VC's mother [REDACTED] and since the VC's brother has been in his care, he has not had [REDACTED]. He reports he is [REDACTED]. The VC's father did come to the agency office on 11/2/11 and signed releases to obtain his son's medical information. The medical reports [REDACTED]. The father also reported the VC's mother would [REDACTED]. He also provided photos of the way the VC's mother would wrap VC's older brother in a blanket when he was six months old which was [REDACTED].

SCCYS was notified on 10/30/11 that the VC had passed away at 7:42 p.m. after she was taken off life support.

Releases were signed for medical records from the following medical providers:

[REDACTED]

Other family members were interviewed and expressed concerns regarding the VC's mother's behaviors while overseeing the VC at Geisinger Medical Center. It was reported she showed no emotion and would say she "was bored".

On 11/2/11, SCCYS CW [REDACTED] and Supervisor, [REDACTED], completed a successful visit to the home of the VC's mother. The VC's mother had already had the majority of the VC's things packed up. There were several hazards for a child of the VC's age present within the home. A [REDACTED]

[REDACTED]. The VC's mother agreed for the agency to take [REDACTED]. There was very little medication missing from the bottle. The VC's mother could not have been giving the VC [REDACTED]. This information was shared with [REDACTED]

SCCYS received [REDACTED]. Within these [REDACTED] there was information [REDACTED]. VC's mother did not follow through with [REDACTED]. On 10/20/11, the VC was again seen [REDACTED]

[REDACTED]. The VC was to be on [REDACTED]

The case [REDACTED]. The case is currently [REDACTED] there are no other children residing in the home. The VC's brother remains with his father in [REDACTED]. To date, no charges have been filed against the mother.

County Strengths and Deficiencies as Identified by the County's Fatality Report

A review team meeting was held on 11/22/11 with various members of the community and community providers. The family was not known to any of the community providers who attended the meeting. At this meeting, information was provided regarding the report [REDACTED]

[REDACTED]. Team members expressed concerns and questioned how [REDACTED]

[REDACTED] had reported Schuylkill Medical Center-South

Jackson no longer has the capability of completing [REDACTED] and typically infants [REDACTED]. The team also expressed concerns and questioned why a report was not made to SCCYS when the mother [REDACTED]. The agency did report that at times they do get calls regarding these situations and the agency immediately responds to ensure the child [REDACTED]. There was discussion regarding [REDACTED] discussed how she and CPS supervisor, [REDACTED], had completed a SCAN presentation at the hospital, however only nursing students had attended. [REDACTED] reported she would discuss the issues with the board and again attempt to provide more education to hospital staff. It was also noted the Children and Youth Services in Schuylkill County have an excellent relationship with their police department and they work collaboratively on cases.

Department of Public Welfare Findings:

SCCYS conducted a thorough investigation in this case. As mentioned previously, SCCYS had no prior involvement in this case. As a result of the fatality review meeting, the SCCYS, along with the community members involved identified some areas that needed improvement. The members identified the fact that SCCYS was [REDACTED]. The pediatrician on the team advised she would discuss this with the hospital and attempt to get more hospital staff to attend trainings related [REDACTED]. The autopsy report came back with cause of death listed as "undetermined" and criminal charges have not been filed, but the criminal investigation is ongoing.

Berks County held their Act 33 meeting on 10/09/12. Berks County did not identify any areas of concern. Because the allegations from the hospital were not considered new information, the County did not respond. Berks County reports that there were no concerns from the hospital regarding the mother's parenting or current mental health. The medical personnel in attendance did question the child moving from one practice to another, but because the moves coincided with the mother's move from Berks County to Schuylkill County, it likely did not cause any concern. Prior to the child's move to Schuylkill County, [REDACTED]. They were in attendance at the Act 33 meeting and [REDACTED]. The VC's mother was taking the VC for [REDACTED] and the she was doing well. They did not see any [REDACTED].

A [REDACTED] was completed on 10-28-12, a [REDACTED] 10-31-11, and on 12/13/11 [REDACTED]. The Mother [REDACTED]. The [REDACTED] no further services were provided due to the fact that there are no other children in the home.